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GAO

Report to the Chairman, Special Committee on Aging, U.S. Senate

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AGING ISSUES

Related GAO Reports and Activities in Fiscal Year 1990

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Human Resources Division

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The Honorable David Pryor
Chairman, Special Committee
on Aging
United States Senate

Dear Mr. Chairman:

This report is in response to the Committee's September 24, 1990, request for a compilation of our fiscal year 1990 products, ongoing work, and other activities regarding older Americans.

Our work covered a broad range of elderly issues, including income security, health care, housing, social and community services, employment, and age discrimination. Some federal policies, such as social security and Medicare, are directed primarily to the elderly. Other federal policies, such as social services block grants, food stamps, or Medicaid, target the elderly as one of several groups served by a program or funding mechanism.

In the appendixes, we describe five types of GAO activities that relate to older Americans:

- Reports on policies and programs directed primarily at older Americans (see app. I).
- Reports on policies and programs that include the elderly as one of several target groups (see app. II).
- Congressional testimonies on issues related to older Americans (see app. III).
- Ongoing work on issues related to older Americans (see app. IV).
- Other activities by GAO officials, such as speaking engagements, publications, and interviews by the media, on issues related to older Americans (see app. V).

These products, ongoing work, other activities, and the issues addressed are presented in table 1. The table shows that we most often addressed elderly health issues during fiscal year 1990.

Table 1: GAO Activities Relating to the Elderly in Fiscal Year 1990

	Type of activity				
Issue	**Reports focused on the elderly**	**Reports with elderly as one of several target groups**	**Testimony**	**Ongoing activities as of 9/30/90**	**Other activities[a]**
Food assistance	0	7	4	2	1
Health	27	13	14	46	26
Housing	0	6	5	10	6
Income security	15	8	9	40	4
Social and other services	1	0	1	0	5
Veterans[b]	9	5	2	10	0
Other	3	2	0	0	0
Total	**55**	**41**	**35**	**108**	**42**

[a]Includes speaking engagements and publications.

[b]Includes veterans' health issues.

Appendix I provides summaries of 55 issued reports on policies and programs directed primarily at the elderly. The reports address food assistance, health, housing, income security, social and other services, and veterans' issues. We also discuss other activities, such as the Older Americans Act.

Appendix II provides summaries of 41 reports in which the elderly were one of several target groups for specific federal policies. These activities are generally financed in conjunction with services to other populations. For example, block grants fund community services or energy assistance for the elderly as well as services for other age groups; Medicaid finances nursing home care as well as financing medical care for poor people of all ages; and Native American programs fund social and health services for Native American elderly as well as programs for other Native Americans.

Appendix III describes the 35 testimonies given in fiscal year 1990 on subjects focused primarily on older Americans. We testified most often on health issues.

In appendix IV we have listed 108 studies directly related to older Americans that were ongoing as of September 30, 1990.

In addition, GAO officials often participated in news interviews and professional and academic panels, and presented papers on topics on which they have particular expertise. Appendix V describes these activities.

You also asked for information on our employment of older Americans. As you are aware, our policies prohibit age discrimination (see app. VI). On September 30, 1990, about 54.8 percent of our workforce was 40 years of age or older. We continue to provide individual retirement counseling and group preretirement seminars.

As arranged with your office, we are sending copies of this report to interested congressional committees and subcommittees. Copies also will be made available to others on request.

This report was prepared under the direction of Linda G. Morra, Director, Human Services Policy and Management Issues, who may be reached on (202) 275-1655 if you have any questions.

Other major contributors are listed in appendix VII.

Sincerely yours,

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

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Appendix II Fiscal Year 1990 GAO Reports on Issues Affecting the Elderly and Others

Abbreviations

ADL	activities of daily living
ADP	automated data processing
ALJ	administrative law judge
AOA	Administration on Aging
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DDS	Disability Determination Service
DOD	Department of Defense
EEOC	Equal Employment Opportunity Commission
ERISA	Employee Retirement Income Security Act of 1974
FAA	Federal Aviation Administration
FDA	Food and Drug Administration
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
HUD	Department of Housing and Urban Development
IRS	Internal Revenue Service
LIHEAP	Low-Income Energy Assistance Program
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
PBGC	Pension Benefit Guaranty Corporation
PMA	premarket approval process
PRO	peer review organization
SSA	Social Security Administration
USDA	U.S. Department of Agriculture
VA	Department of Veterans Affairs

Fiscal Year 1990 GAO Reports on Issues Primarily Affecting Older Americans

During fiscal year 1990, we issued 55 reports on issues primarily affecting the elderly. Of these, 27 were on health, 15 on income security, 1 on social services, 9 on veterans' issues (including 7 on veterans' health care), and 3 on other issues. An asterisk after the report title indicates that the review was performed at the request of Committees or Members of Congress. Two asterisks indicate that the work was mandated by statute. When no asterisks are noted, the work was undertaken as part of GAO's basic legislative responsibility to audit and evaluate Federal agencies and programs.

Health

Employee Benefits: Extent of Multiemployer Plan Retiree Health Coverage (GAO/HRD-90-132, July 17, 1990)*

To what extent do companies provide retiree health coverage indirectly, through multiemployer plans? Although just over 6 percent of all retirees in company-sponsored health plans are covered by multiemployer plans, these plans are an important source of coverage in certain industries—most notably construction—where few individual firms have retiree health benefits. GAO analyzed data on 915 plans and determined the numbers of (1) multiemployer health plans with retiree coverage, (2) workers enrolled in such plans, and (3) retirees in such plans. GAO also estimated the total number of private sector workers and retirees in company-sponsored health plans with retiree coverage.

Health Care: Criteria Used to Evaluate Hospital Accreditation Process Need Reevaluation (GAO/HRD-90-89, June 11, 1990)*

The Health Care Financing Administration (HCFA)—part of the Department of Health and Human Services (HHS)—relies on the Joint Commission on Accreditation of Healthcare Organizations to identify and resolve problems in hospitals serving Medicare patients. However, HCFA lacks assurances that the hospitals surveyed by the Joint Commission are complying with Medicare requirements. While HCFA is unsure of the extent to which it can direct the Joint Commission to change its accreditation process to meet HCFA's needs, GAO believes that HCFA should try to guide the Joint Commission to ensure that hospitals meet Medicare requirements. If such efforts are unsuccessful, alternatives to the present system of accreditation can be considered. However, because none of the alternatives appears to be clearly superior to the present system, GAO discusses several options for improving the system. GAO summarized this report in June testimony before the Congress.

Long-Term Care Insurance: Proposals to Link Private Insurance and Medicaid Need Close Scrutiny (GAO/HRD-90-154, Sept. 10, 1990)*	Several state demonstration projects have been proposed to coordinate private long-term care insurance with Medicaid. The goal of the projects is to see whether the promotion of long-term care insurance for the elderly will yield more adequate long-term care protection without increasing public sector costs. Although the projects vary significantly, most propose allowing people who buy a qualifying private long-term policy to become Medicaid-eligible after the policy pays for a period of long-term care costs. Participants would not have to "spend down" or deplete as much of their savings as is now required to meet Medicaid eligibility thresholds. GAO believes that the proposed projects could reduce the financial hardships that some elderly endure as a result of catastrophic long-term care costs. On the other hand, risks would be involved if the projects are given authority to link private insurance coverage with Medicaid. GAO summarized this report in testimony before the Congress.
Medicaid: Sources of Information on Mental Health Services (GAO/HRD-90-100, May 7, 1990)*	The availability of mental health services under Medicaid has been a concern to many health experts. This report identifies sources of information on the types of mental health services offered under each state's Medicaid program. GAO found that several federal agencies publish data about (1) Medicaid and mental health expenditures and (2) numbers of recipients of services for each state. However, these agencies publish little information about the specific mental health services available to recipients in each state. Academic, professional, and advocacy groups publish more detailed information about the mental health services available to Medicaid recipients. The reports by these organizations include information on expenditures, eligibility criteria, services covered, and limitations on the availability of those services.
Medicare and Medicaid: More Information Exchange Could Improve Detection of Substandard Care (GAO/HRD-90-29, Mar. 7, 1990)	Peer review organizations, Medicare carriers, and state Medicaid agencies do not now routinely exchange information about physicians they have identified as providing unnecessary or poor-quality care. GAO recommends that HCFA require these groups to routinely exchange such information. Such an exchange, in GAO's view, would improve detection of such care in the Medicare and Medicaid programs; this, in turn, could shorten the time needed to initiate action to change the behavior of physicians responsible for these problems.

Medicare Appeals Process: Part B Changes Appear to Be Fulfilling Their Purpose (GAO/HRD-90-57, July 16, 1990)*/**

The Medicare Part B program provides supplemental medical insurance coverage to individuals age 65 and older. In 1987 the process by which claimants could appeal decisions was changed to provide an appeals opportunity beyond that provided at the insurance carrier level in cases that involved disputes of $500 or more. Claimants could elect on-the-record, telephone, or in-person hearings at the carrier level, before an appeal was made to a federal administrative law judge (ALJ). In 1988 HCFA introduced the requirement that Part B cases go through a mandatory on-the-record hearing before being appealed. If disputed amounts still were more than $500, claimants could then appeal to an ALJ.

GAO examined the effects of these changes and found that the percentage of cases receiving a telephone or in-person hearing at the carrier level decreased after the introduction of mandatory on-the-record hearings. The percentage of cases appealed to an ALJ increased. GAO reports that the changes to the Part B appeals process seem to be fulfilling their purpose of reducing the number of in-person and telephone hearings and providing claimants an opportunity to appeal beyond the carrier level. GAO did not attempt to determine the reason for its additional observation that the percentage of case decisions resulting in payments to claimants decreased after on-the-record hearings became mandatory.

Medicare Catastrophic Act: Estimated Effects of Repeal on Medigap Premiums and Medicaid Costs (GAO/HRD-90-48FS, Nov. 6, 1989)*

GAO surveyed commercial Medicare supplemental insurance (Medigap) companies and state Medicaid agencies to obtain their estimates of how the repeal of the Medicare Catastrophic Coverage Act of 1988 would affect Medigap premiums and Medicaid budgets. GAO contacted 29 of the commercial insurers that had over $10 million of earned premiums on Medigap policies during 1987. These commercial insurers said the act's repeal would increase monthly premiums by an average of 15.4 percent. The estimated monthly increases ranged from 6.3 to 41.3 percent. For the 2.5 million subscribers, the repeal would cause projected premium increases of about $250 million in 1990. GAO also received responses from the Medicaid offices in 37 states and the District of Columbia as to how repeal of the act's Medicare benefit changes would affect their 1990 Medicaid budgets. These states estimated that repeal would increase their Medicaid budgets by about $1 billion, of which about $444 million would be state funds and about $587 million would be federal matching funds.

Medicare Part A Reimbursements: Processing of Appeals Is Slow (GAO/HRD-90-23BR, Feb. 9, 1990)**

GAO reviewed the adequacy of staffing levels at the Provider Reimbursement Review Board, a five-member quasijudicial body established under the hospital insurance portion (Part A) of the Medicare program. The Board conducts hearings and issues decisions on appeals by hospitals, skilled nursing facilities, and home health agencies on the amount of reimbursement Medicare allowed for beneficiaries' care. GAO found no evidence that HCFA, which administers Medicare, deliberately intended to impair the Board's effectiveness by limiting staff allocations. Nevertheless, HCFA's allocation of resources did impair the Board's ability to process cases. It is difficult to determine accurately the number of staff the Board needs to process cases in a timely manner. The Board has no accurate count of the cases in inventory and may not have realistic time frames for each step in the process. If the Senate Committee on Appropriations wishes to directly monitor the level of resources requested for the Board's operations, it may want to consider directing that the Board be identified separately in the HHS appropriation request.

Medicare: Alternatives for Computing Payments for Hospital Outpatient Surgery (GAO/HRD-90-78, Apr. 3, 1990)*

GAO notes that Medicare may be paying more than necessary for hospital outpatient surgery because of current methods of calculating patient reimbursement. A Medicare prospective payment system for surgery done in hospital outpatient departments is being considered and, if adopted, should eliminate many of the shortcomings of the current system. Because it may be a while before a new system starts up, an interim solution may be desirable. This report discussed three alternatives to the existing payment methodology that the Congress should consider.

Medicare: Assuring the Quality of Home Health Services (GAO/HRD-90-7, Oct. 10, 1989)*

Medicare spending for home health services rose from $1.5 billion to an estimated $2.8 billion between fiscal years 1983 and 1989. The number of agencies providing these services increased by 43 percent to almost 6,100. HCFA, which is responsible for ensuring the quality of home health services, contracts with the states to periodically survey home health agencies and find out whether they are complying with HCFA standards.

GAO found that HCFA guidance has not resulted in surveyors using sound methods to (1) sample the patient records they review and (2) interpret Medicare standards consistently in order to present an accurate picture of home health agency performance. In addition, HCFA has not given the states pertinent information gathered by its claims-processing contractors and peer review organizations (PROs) for use in assessing compliance with Medicare standards. HCFA is developing training standards for

personnel who provide high-tech treatments to Medicare patients in their homes. Current law, however, does not require HCFA to develop training standards for all such personnel. The Congress has revised many aspects of the home health agency certification process in order to improve home care quality. The next step is for HCFA to issue regulations and procedural guidance that will help the home health agencies and the states implement these revisions.

Medicare: Comparative Analyses of Payments for Selected Hospital Services (GAO/HRD-90-108, July 6, 1990)*

One of the goals of the Medicare prospective payment system for inpatient hospital services is to set payment rates that are reasonable from Medicare's perspective and, at the same time, equitable to hospitals. This goal has been a challenge in part because the Medicare Hospital Cost Report—the main source of hospital cost and revenue information needed for policymakers—does not provide all the financial information needed to evaluate Medicare payments rates. This report analyzes hospital costs and revenues in terms of the adequacy of Medicare payment rates. GAO compared Medicare payment rates for inpatient hospital services with Medicaid payments for these same services in California, New York, and Ohio. GAO also analyzed differences among these states in Medicare payments and costs for similar inpatient services. GAO found that, on average, hospitals in all three states were paid a greater percentage of billed charges for Medicare patients than for Medicaid patients.

Medicare: Comparison of Two Methods of Computing Home Health Care Cost Limits (GAO/HRD-90-167, Sept. 28, 1990)**

In 1989 Medicare paid home health agencies about $2.8 billion for visits made to beneficiaries. Medicare pays for six types of home health visits: skilled nursing; physical, speech, and occupational therapy; medical social services; and home health aide. GAO estimates that Medicare costs would have been cut by 2.5 percent—or $49 million—if cost limits had been applied by type of visit for cost-reporting periods during the year beginning July 1, 1989. While applying cost limits by type of visit would have reduced payments to twice as many agencies as applying the limits in the aggregate, the payment reductions would have been small for most agencies.

GAO surveyed agencies that would have faced additional reductions if type-of-visit cost limits had been used. Over 40 percent of these agencies said that the additional reductions would have caused them to stop participating in Medicare or to curtail services. In most cases, however, GAO found other agencies in the same geographic areas that were willing and

able to expand service even if type-of-visit limits were used. GAO estimates that 1.8 percent of home health visits to beneficiaries would be unavailable if type-of-visit limits were adopted. On a related matter, GAO found that changing the cost-limit-computation method—from the 75th percentile of home health agencies to 112 percent of mean costs—had little effect on limit levels. The purpose of cost limits is to give home health agencies incentives to control cost growth. In the final analysis, the question is whether the additional cost savings from applying cost limits by type of visit are worth the small decrease in beneficiary access that could result.

Medicare: Employer Insurance Primary Payer for 11 Percent of Disabled Beneficiaries (GAO/HRD-90-79, May 10, 1990)**

The Omnibus Budget Reconciliation Act of 1986 made Medicare the secondary payer for medical expenses of certain disabled beneficiaries covered by large group health plans. The act also required that GAO determine the number of beneficiaries for whom Medicare became the secondary payer because of their own or a family member's employment. Overall, GAO estimates that during 1988, Medicare became the secondary payer for 340,000 disabled beneficiaries, or about 11 percent of the 3.1 million disabled Medicare beneficiaries.

Medicare: HCFA Can Reduce Paperwork Burden for Physicians and Their Patients (GAO/HRD-90-86, June 20, 1990)*

The paperwork required to process claims under Medicare is burdensome and confusing to many beneficiaries and care providers alike. This report examines the paperwork required in the claims process for Medicare Part B to see whether (1) opportunities exist to help providers submit complete claims, (2) notices to beneficiaries explain claims decisions clearly, and (3) electronic services like electronic mail could reduce paperwork.

Medicare: Improvements Needed in the Identification of Inappropriate Hospital Care (GAO/PEMD-90-7, Dec. 20, 1989)*

Over 31 million elderly Americans look to Medicare as their primary way of obtaining hospital care. In fiscal year 1988, payments for inpatient hospital services totaled $51.9 billion. In the Medicare program, 54 Utilization and Quality Control PROs judge the appropriateness of hospital care given Medicare beneficiaries as well as other aspects of care, including the quality and accuracy of hospital classification decisions affecting reimbursement levels.

GAO found that PRO reviews of hospital care have typically identified a lower rate of inappropriate care than have reviews done by an independent HCFA contractor or by researchers. The criteria used to screen cases, the cases selected for review, and the lack of incentives for PROs to

aggressively question the appropriateness of care all tend to decrease the rate of inappropriate hospital care uncovered by the PRO reviews. The main difference between private sector and PRO utilization review activities is timing. Private sector programs operate prospectively—that is, before admission, identifying patients who do not need hospitalization and referring them to more appropriate health care settings. Most PRO reviews, on the other hand, are done after the patient has been discharged from the hospital.

Medicare: Increase in HMO Reimbursement Would Eliminate Potential Savings (GAO/HRD-90-38, Nov. 1, 1989)*

On the basis of its review of the history of health maintenance organizations (HMO) Medicare reimbursement, GAO believes that raising the payment rate from 95 to 100 percent of the adjusted average per capita cost would be contrary to what the Congress envisioned. The Congress expected that paying HMOs 95 percent of the average per capita cost would cost 5 percent less than if enrollees remained under fee-for-service programs. Increasing the payment rate to 100 percent would eliminate any savings potential. The Congress was also concerned that inaccuracies in the adjusted average per capita cost could lead to excessive payments to HMOs. Recent studies, in fact, have concluded that Medicare beneficiaries enrolled in HMOs tend to be healthier and less costly to treat. They also concluded that the methodology used to calculate the adjusted average per capita cost does not accurately reflect these cost differences. Thus, rather than paying less, Medicare actually may have paid more for enrollees under HMO than had they remained in the fee-for-service sector. GAO believes that HMOs' payment rates should not be changed until these issues are resolved.

Medicare: Increased Denials of Home Health Claims During 1986 and 1987 (GAO/HRD-90-14BR, Jan. 24, 1990)*

Medicare provides a home health care benefit for beneficiaries who are confined to their homes, under a physician's care, and in need of part-time intermittent skilled nursing care or physical or speech therapy. Congressional concern over increased denials of Medicare home health care claims during 1986 and 1987 prompted GAO to look into the situation. This briefing report addresses the reasons for the increased denials, the extent and causes of variation in denial rates among regions of the country, the number of home health agencies that lost their waiver of liability during this period, and the effects of the increased denials on the appeals process.

Medicare: Internal Controls Over Electronic Claims for Anesthesia Services Are Inadequate (GAO/HRD-90-49, Dec. 18, 1989)**

During its review of Medicare payments to anesthesiologists, GAO found that internal controls were inadequate for claims for anesthesia services submitted by electronic media like magnetic tape or disk. Controls over electronic claims at seven of eight carriers in GAO's review were not as effective as controls used in paying paper claims. When GAO sampled electronic claims at three carriers, GAO found computational errors that could have been detected had the controls for reviewing paper claims been employed. A subsequent audit by one of these carriers disclosed net overpayments to an anesthesiology group of about $117,000. HCFA needs to improve its electronic media claims control policies and to review carrier compliance with such policies.

Medicare: Options to Provide Home Dialysis Aides (GAO/HRD-90-153, Aug. 31, 1990)*

Home Intensive Care, Inc., stopped providing aides to its home patients in February 1990, when the Omnibus Reconciliation Act of 1989 began limiting payments to suppliers of dialysis equipment and supplies to the amount that facilities receive for dialysis treatment. As a result, alternative dialysis sources had to be found for many of Home Intensive Care's home dialysis patients. HCFA found alternative dialysis sources for all 1,553 former home dialysis patients who received paid aides, although as of August 1990, 16 patients had not been placed with a permanent alternative source. GAO looked at the circumstances under which it might be appropriate to authorize Medicare payments for an aide under the end renal stage disease program when patients dialyze at home. GAO also reviewed increased indirect costs like transportation and day care incurred by Home Intensive Care patients after the firm stopped providing aides for home dialysis.

Medicare: Payments for Home Dialysis Much Higher Under Reasonable Charge Method (GAO/HRD-90-37, Oct. 24, 1989)*

GAO examined the payments Medicare was making to Home Intensive Care, Inc., for furnishing dialysis supplies and equipment to patients who receive kidney dialysis at home. GAO found that in Florida, where the majority of Home Intensive Care's Medicare claims are processed for payment, the firm received almost $2,500 per home patient per month from Medicare. In contrast, dialysis facilities that served home facilities received about $1,240 per month for serving home patients. A February 1989 HCFA analysis also concluded that total Medicare payments were higher for Home Intensive Care patients than for facility patients. GAO questions whether the additional payments are a prudent expenditure of Medicare funds and supports HCFA efforts to limit payments for home dialysis supplies and equipment.

Medicare: Second Status Report on Medicare Insured Group Demonstration Projects (GAO/HRD-90-117, June 6, 1990)**	HHS is authorized to conduct demonstrations of contracting on a prepaid capitation basis with Medicare Insured Groups to provide Medicare benefits to retirees. HCFA has been working for about 2 years to implement the demonstration projects. Currently, none of the projects has progressed further than the feasibility analysis phase. At the end of its feasibility analysis, Chrysler decided not to proceed with the demonstration, concluding that it would have been unprofitable. In addition, little progress has been made in the last year by Amalgamated or Southern California Edison. Neither company has developed a method of setting capitation rates that HCFA has approved. Both companies have received extension of the feasibility analysis phase of their cooperative agreements. In this second status report, GAO concludes that it is unclear when any Medicare Insured Group project will become operational.
Medicare: Statistics on the Part B Administrative Law Judge Hearings Process (GAO/HRD-90-18, Nov. 28, 1989)*	This report provides statistics on the administrative law judge portion of the Medicare Part B appeals process. Specifically, the report discusses the number of ALJ cases filed and their status, the outcome of cases by type of hearing sought, and the time required to complete the hearing process.
Medicare: Withdrawing Eyeglass Coverage Recommended Following Cataract Surgery (GAO/HRD-90-31, Feb. 8, 1990)*	Although Medicare does not cover conventional eyeglasses, an exception has been made for individuals who have undergone cataract surgery. The reasoning is that glasses in these cases are considered to be prosthetic devices. The goal of conventional eyeglasses for both cataract surgery patients and others is to improve focus for near or distance vision. Because Medicare generally prohibits payments for this purpose, GAO questions payments for beneficiaries who have had cataract surgery. In 1984 GAO recommended that Medicare drop coverage of conventional eyeglasses following cataract surgery. This report reiterates that recommendation. On the basis of 1987 payments, GAO estimates that its recommendation would save over $98 million annually.
Medicare Catastrophic: Roll Back of Premiums on Schedule (GAO/IMTEC-90-30, Mar. 16, 1990)*	GAO looked at the Social Security Administration's (SSA) efforts to stop withholding Medicare catastrophic coverage premiums. Although the Congress repealed most provisions of the Medicare Catastrophic Coverage Act of 1988 effective January 1, 1990, SSA was unable to stop withholding catastrophic coverage payments by that date without jeopardizing timely payment of Social Security benefits. The May 1990 Social Security checks will be the first not to have catastrophic coverage

premiums withheld. Consequently, the Treasury will issue two refunds—one in February and one in April. The government will spend about $49 million to return the excess withholding of $572 million. SSA officials acknowledge that withholding premiums could have been stopped sooner if the agency's software programs for catastrophic coverage premiums had been better organized and easier to maintain. Reducing the time needed to reprogram SSA's computers might have eliminated the need for a second refund check, thereby lowering overall costs. The lack of well-organized, easy-to-maintain software is a long-standing problem that SSA is addressing in its efforts to overhaul its computer systems.

Nursing Homes: Admission Problems for Medicaid Recipients and Attempts to Solve Them (GAO/HRD-90-135, Sept. 5, 1990)*

Medicaid recipients have more difficulty getting into nursing homes than do higher-paying private payers. Equalizing payment rates for the two groups, or reducing the difference between their payment rates, would improve access for Medicaid recipients. Establishing rates that are scaled to the severity of Medicaid recipient care needs would be another way to improve access for those with "heavy" care needs. Increasing Medicaid rates, however, would cost more money, and some states—citing competing demands for limited resources—question the affordability of such measures. To avoid higher Medicaid spending, some states have restricted the supply of nursing home beds, and, thereby, created a shortage. Faced with these shortages, some states have tried regulatory reforms, with uncertain effectiveness, to allocate existing beds so that Medicaid recipients and private payers have the same chance of getting an available bed.

Rural Hospitals: Federal Leadership and Targeted Programs Needed (GAO/HRD-90-67, June 12, 1990)*

Because of mounting financial pressures, many rural hospitals have closed in recent years, and many more are at risk of closing. There is widespread concern that many people, particularly elderly and low-income individuals, may have difficulty traveling to another facility to receive care. This report discusses strategies and programs at the state and federal levels to address the problems facing rural hospitals.

GAO concludes that because of the rapid changes in the health care industry and the complexity of the problems facing rural hospitals, it is unrealistic to expect that every rural hospital will remain open as a full-service facility. To help preserve rural residents' access to hospital care, GAO recommends that HHS (1) improve the monitoring of and technical support provided to sole community hospitals and (2) ensure that its Office of Rural Health Policy has the resources to monitor and evaluate

the impact of federal efforts to assist rural hospitals. In addition, the Congress may wish to require that essential rural hospitals that are financially at risk be given priority when applying for federal grants.

Screening Mammography: Low-Cost Services Do Not Compromise Quality (GAO/HRD-90-32, Jan. 10, 1990)*/**

Every year breast cancer kills over 40,000 Americans, mostly women. The best tool available today for early detection is mammography, an x-ray that can find cancers too small to feel. While the Medicare Catastrophic Coverage Act of 1988 made screening mammography for symptom-free women a new Medicare benefit, it limited the charge for Medicare-funded screening to $50. In looking at whether this limit could compromise women's ability to obtain quality services, GAO found that many providers lack adequate quality assurance programs. This may contribute to the wide range of image quality and patient radiation dose that occurs in mammography practice. GAO found no relationship between the price charged for screening mammography and adherence to quality standards. Providers with higher mammography volume, however, were more likely to comply with quality standards than were those with lower volume. There is evidence that high volume permits economies of scale and does not compromise quality. GAO found that the absence of legally binding quality standards has limited federal and state oversight programs. In September 1989, HHS published proposed regulations for Medicare-funded screening mammography that parallel professional quality standards. However, because the Congress repealed the Medicare Catastrophic Coverage Act of 1988, HHS will withdraw its proposed regulations.

Income Security

ADP Systems: EEOC's Charge Data System Contains Errors but System Satisfies Users (GAO/IMTEC-90-5, Dec. 12, 1989)*

GAO looked at whether the Equal Employment Opportunity Commission's (EEOC) Charge Data System can provide accurate, complete, and current data to EEOC in its administration and enforcement of the Age Discrimination in Employment Act. Concerns had been raised that the system may have been partly responsible for age discrimination complaints exceeding the statute of limitations before EEOC had completed its investigations. Age discrimination cases in the Charge Data System data bases of the eight offices GAO visited contained some errors, but the users were largely satisfied with the system. These errors occurred because EEOC did not adequately verify the accuracy or completeness of data entered in the data bases or update the data bases with new or

revised data. Although data base errors diminish the accuracy of system reports, they did not adversely affect the investigation of age discrimination complaints. None of the cases selected at random for GAO's analysis exceeded the statute of limitations. While EEOC's Director of Management was concerned about the error rates and said that EEOC recently had acted to reduce the level of error in the data bases, EEOC has not established a standard for an acceptable level of error. Establishing a cost-effective data accuracy standard and adhering to it is a reasonable and accepted practice among users of management information systems.

Age Discrimination: Use of Age-Specific Provisions in Company Exit Incentive Programs (GAO/HRD-90-87BR, Feb. 27, 1990)*

Age-specific provisions in company exit incentive programs either bar a certain group of older workers from program participation or exclude these workers from enhanced benefits available to younger eligible workers. Companies sometimes use short-term exit incentive programs to reduce their work forces when downsizing their operations. Although very few of the exit incentive programs GAO identified had age-specific provisions for eligibility, most used age-specific provisions for enhanced benefits. Specifically, GAO found that only 5 percent of the Fortune 100 company exit incentive programs used age-specific eligibility provisions. These programs used age brackets or set a cap on the age of workers to which the incentive was offered. GAO also found that a majority of existing incentive programs offered workers age-specific enhanced benefits.

District's Workforce: Annual Report Required by the District of Columbia Retirement Reform Act (GAO/GGD-90-70, Apr. 4, 1990)**

This report contains GAO's comments on a report by an actuary on the disability retirement rate of District of Columbia police officers and fire fighters. The District of Columbia Retirement Reform Act provides for annual federal payments to the D.C. Police Officers and Fire Fighters' Retirement Fund. These payments, however, must be reduced when the disability retirement rate exceeds an established limit. This is to encourage the D.C. government to control disability retirement costs. In GAO's opinion, the determination made by the enrolled actuary meets, in all material respects, the requirement of the law. Since the disability retirement rates calculated by the actuary are both less than 0.8 percent, no reduction is required in the fiscal year 1991 payment to the District's police and fire fighters' retirement fund.

Employee Benefits: Extent of Companies' Retiree Health Coverage (GAO/HRD-90-92, Mar. 28, 1990)*

Companies provide health coverage to active workers more often than they do to retirees. Only about 4 percent of companies provide retiree health coverage. However, because these companies tend to be larger, a relatively high percentage of people—about 40 percent of private sector employees—work for firms with retiree health coverage. Since 1984 fewer than 1 percent of companies have terminated a health plan that resulted in retirees or active workers losing their health coverage. Yet companies are trying to limit retiree health costs. Over one-third of companies with health plans for active workers or retirees require participants to help pay for coverage. Existing law provides limited protection to current and future retirees against company actions to reduce or terminate benefits. In addition, the proposal by the Financial Accounting Standards Board that companies recognize retiree health liabilities on their financial statements has caused some companies to reconsider whether they will be able to continue providing benefits. The Congress has several options if it decides to strengthen the security of retiree health benefits. These options range from (1) applying a full pension-type model, including requiring advance funding regulated by comprehensive legislation like the Employee Retirement Income Security Act of 1974, to (2) requiring companies with health plans to allow retirees under age 65 to purchase coverage at group rates similar to the coverage now provided by 1985 legislation.

Job Training Partnership Act: Information on Set-Aside Funding for Assistance to Older Workers (GAO/HRD-90-59FS, Jan. 22, 1990)*

Under Title IIA of the Job Training Partnership Act, funding has been set aside to help train and employ older workers. Seventy-eight percent of annual funding to states under this title is devoted to job training eligible people, including older workers, at the local level. In addition, 3 percent of the state allocation is set aside specifically to help economically disadvantaged older workers. This fact sheet provides information on the extent to which states have been able to spend their 3 percent set-aside funds. Information is also provided on the expenditure rate of other Job Training Partnership Act programs, for comparison, and the extent to which the act is serving older workers.

Pension Plans: Public Plans in Four States Have Generally Similar Policies and Practices (GAO/HRD-90-133, July 24, 1990)*

Some 2,400 public employee pension plans with over $600 billion in assets cover 11.8 million workers in the Unites States. Public employee plans are exempt from the Employee Retirement Income Security Act of 1974, which protects plan participants and beneficiaries in the private sector. In response to concerns about the protections afforded public plan beneficiaries by state laws, this report provides information on

public pension plans in four states. GAO discusses the plans' administrative organization; fiduciaries and their responsibilities; funding processes; investment policies and practices; and oversight, reporting, and disclosure. Overall, GAO found the pension plans for state and local government employees in the four states to be similar in many ways.

Pension Plan Terminations: Effectiveness of Excise Tax in Recovering Tax Benefits in Asset Reversions (GAO/HRD-90-126, July 13, 1990)*

To encourage savings for retirement, tax policy favors defined benefit and other pension plans. Federal law now permits sponsors to terminate their pension plans, pay each participant only the benefits that have built up to the termination date, and keep all the residual assets. Since 1980, it is estimated that reversions by employers in this way have amounted to $20 billion.

GAO evaluated the 15-percent excise tax levied on employers who recover excess pension assets by terminating overfunded pension plans—called asset reversions—and found that it was not high enough to offset the tax benefit portion of pension asset reversions. According to GAO's analysis, the excise rates needed to fully offset pension tax benefits ranged from 17 to 59 percent. These offsetting excise tax rates were very sensitive to variations in the way different types of income were taxed. For example, plans that primarily obtained their investment income from sources normally subject to the maximum statutory rate, such as income from corporate bonds, had the highest offsetting tax rates.

Private Pensions: Impact of New Vesting Rules Similar for Women and Men (GAO/HRD-90-101, Aug. 21, 1990)**

For workers who change jobs, vesting in pension benefits can add to retirement income. Vesting—gaining the nonforfeitable right or entitlement to employer-provided pension benefits—is largely dependent on years of employment with the company sponsoring the plan. The Tax Reform Act of 1986 cut the maximum allowable vesting period in half for most workers in qualified private pension plans. The act targeted plans that were not "top-heavy," meaning those in which over 60 percent of the benefits or contributions go to company owners or other key employees. Prior vesting rules do not meet the needs of many workers who change jobs frequently and so do not vest in their pension plans. Women are one such group disadvantaged by these rules. GAO found that the vesting changes in the Tax Reform Act of 1986 will improve the vesting status of shorter-term workers, with a similar effect on women and men.

Private Pensions: Impact of Vesting and Minimum Benefit and Contribution Rules in Top-Heavy Plans (GAO/HRD-90-4BR, Oct. 23, 1989)*

A pension plan is top-heavy when more than 60 percent of the benefits or contributions go to company owners, officers, or other key employees. The Employee Retirement Income Security Act of 1974 set vesting rules for pension plans, governing the length of time before a participant earned a right to receive pension benefits. The Tax Equity and Fiscal Responsibility Act of 1982 added special rules for top-heavy plans that reduced the maximum time such plans could require for vesting, and increased the likelihood of shorter tenured workers receiving pension benefits. However, the Tax Reform Act of 1986 significantly lessened the vesting period for plans that were not top-heavy, calling into question the need for special rules for top-heavy plans.

Many more participants, men and women alike, would have had smaller or no vested benefits if the 1982 act's top-heavy vesting rules had been repealed and replaced with the 1986 act's vesting rules in the 55,000 top-heavy plans in GAO's pension database. However, the effect of this change in vesting status on participants' retirement income would likely have been small and would have occurred only if these participants left their jobs before being fully vested. Over one-half of the 26,000 plans and over two-thirds of the 142,000 participants represented in GAO's analysis were not affected by the top-heavy minimums. However, short-service participants (fewer than 3 years' service) appeared to be more likely than those with longer service to be affected by the defined benefit minimums after just 2 years under the top-heavy rules. Only about one-third of short service non-key participants—compared with over two-thirds of longer service participants—had accrued benefits greater than the minimum benefit and so were not affected.

Private Pensions: Spousal Consent Forms Hard to Read and Lack Important Information (GAO/HRD-90-20, Dec. 27, 1989)**

In congressional testimony, witnesses said that some husbands had, without consulting their wives, chosen pension options that paid higher benefits during their own lifetimes but did not provide a continuing benefit to their widows. In many cases, these women were left destitute. The Retirement Equity Act of 1984 now requires employers to obtain written consent from spouses of retiring workers who chose pension benefits payable only during their lifetimes.

GAO examined the content and readability of forms that companies use to meet the act's spousal consent requirement. These consent forms are an important source of information about survivor benefits for spouses as well as workers, particularly since many companies do not formally counsel workers nearing retirement and even fewer counsel spouses.

Despite their importance, many of the forms GAO reviewed did not present all the information GAO believes spouses should have in making an informed decision about the survivor benefit option. Moreover, in GAO's opinion, the consent forms are too difficult for many spouses of retiring workers to understand. GAO believes that the Internal Revenue Service (IRS) should require employers to provide spouses with clearly written consent forms that explain the terms of the various pension benefit options and the consequences of rejecting the survivor benefits.

Reserve Forces: Opportunity to Reduce Pension Costs (GAO/NSIAD-90-152, Aug. 3, 1990)*

Reservists who have the years of service needed for retirement but have not reached retirement age can continue their membership and earn additional credits that are used to calculate their retirement pay. A Department of Defense policy directive, however, requires that reservists maintain a minimum level of participation or be transferred to either an inactive or a retired status in which they can no longer earn retirement credits. Despite this directive, the Army continues to give additional retirement credits to individuals who should have been transferred to an inactive or a retirement status. This also occurs to a lesser extent with the Air Force and the Navy. As of September 1989, almost 6,000 reservists had not met the minimum level of participation required in each of their two most recent service years. GAO estimates that the long-term cost of retirement credits earned by these reservists in their most recent service year could amount to about $5.6 million.

Social Security: Alternative Wage-Reporting Processes (GAO/HRD-90-35, Nov. 8, 1989)*

GAO found that in millions of cases, wages reported by employers to IRS differed from wages reported to the SSA. This could lead to either lower social security benefits or underpayment of social security taxes for workers.

GAO studied the pros and cons of three different alternatives to the existing system of wage reporting. The first makes IRS rather than SSA responsible for receiving and processing reports. SSA now receives all earnings reports, processes them, and sends them to IRS. The second alternative relies on the unemployment compensation earning file, currently the responsibility of the Department of Labor and the states, to check wage data submitted to IRS and SSA. Under the third alternative, the existing process would be scrapped and replaced by a new entity that would receive and process wage data for IRS, SSA, and the states.

Although GAO concluded that there are advantages to each of the alternatives, none are compelling enough to warrant immediate changes to

the existing wage-reporting process. Instead, GAO believes the changes being made by IRS and SSA to the process are a start in the right direction. Possibly the most significant initiative affecting the accuracy of SSA's earning files is SSA's new Personal Earnings and Benefit Estimate Statements, which would give workers a chance to review earnings posted to their Social Security account and to clear up any discrepancies.

Social Security: Many Administrative Law Judges Oppose Productivity Initiatives (GAO/HRD-90-15, Dec. 7, 1989)*

Individuals whose applications for Social Security disability or Medicare benefits have been denied may challenge such decisions before an administrative law judge. The number of appeals to ALJs has risen substantially over the years. SSA Office of Hearings and Appeals manages the ALJs. Over the years, many ALJs have opposed various management practices on the grounds that they interfere with decisional independence. This report examines (1) the causes of recent conflicts between the Office of Hearings and Appeals and the ALJs and (2) whether reductions in staff, especially in judges, adversely affected the adjudicative process.

Social Security: SSA Could Save Millions by Targeting Reviews of State Disability Decisions (GAO/HRD-90-28, Mar. 5, 1990)

SSA spent almost $30 million in fiscal year 1988 reviewing disability decisions made by state disability determination services (DDS). These reviews are done mainly to (1) see whether accuracy standards have been met and (2) correct as many erroneous benefit allowances as possible.

GAO evaluated SSA's effectiveness in achieving this second objective. SSA selects all review cases randomly. While this is appropriate for the quality assurance sample that measures DDS accuracy, the preeffectuation review sample could produce better results if SSA targeted it to categories of cases most susceptible to incorrect DDS decisions. If SSA focused its sample on the more error-prone types of cases, like allowances of claims involving back injuries or chronic lung disease, it could correct more erroneous decisions than it does using a random approach, even with a lower volume of reviews. The current preeffectuation review of DDS continuances change very few DDS decisions. If the resources spent on those reviews were made available for targeted reviews of initial DDS allowances, substantially more incorrect benefit awards would be identified and reversed, with future benefit savings.

Tax Policy: Taxation of Pension Income for Retired New Jersey Police and Firefighters (GAO/GGD-90-73BR, Apr. 13, 1990)*

According to the New Jersey Policeman's Benevolent Association, police and firefighters have shorter life expectancies than do the general public. The association believes that if police and firefighters could use actuarial tables reflecting their shorter life expectancy, their taxable income and, therefore, their taxes in the early years of retirement would be less under current law.

In this briefing report, GAO evaluates the fairness of the actuarial tables used by IRS in computing taxable pension income. GAO also looks at the feasibility of using actuarial tables that take into account occupation and other factors. GAO found that the life expectancies of police and firefighters are essentially the same as those of the general public. In addition, GAO believes that developing separate tables would create a troublesome precedent since other occupational or demographic groups may request their own tables. GAO does recommend that IRS revise its publications to clarify when retirees can use the simplified rule to their advantage.

Social Services

In-Home Services for the Elderly: Cost Sharing Expands Range of Services Provided and Population Served (GAO/HRD-90-19, Oct. 23, 1989)*

A growing number of state and area agencies on aging now charge some elderly clients for in-home services funded through private and government sources—a practice known as cost sharing. Agencies typically use cost sharing for services that are relatively expensive per client, such as adult day care and homemaker services. To preserve their commitment to serving the low-income elderly, cost-sharing agencies have employed protections like sliding fee scales.

GAO surveyed state and area agencies on aging and found that most had a positive attitude toward cost sharing. Agencies that cost share said that it (1) allows them to serve more elderly clients and provide a broader range of services and (2) is more likely to reduce any welfare stigma associated with agency services. Regardless of whether they had cost sharing, respondents generally favored legislation that would specifically authorize the practice.

Veterans

Infection Control: VA Programs Are Comparable to Nonfederal Programs but Can Be Enhanced (GAO/HRD-90-27, Jan. 31, 1990)*

The Centers for Disease Control estimates that 5 percent of all patients who enter a hospital contract an infection during their stay. This means that 60,000 veterans could get infections each year while being treated at Department of Veterans Affairs (VA) hospitals. The 159 medical centers that VA operates throughout the United States are required to have an infection control program to identify existing infections and to prevent future ones.

In the course of its work, GAO found that the program guidance that VA issues to its medical centers was too broad to be helpful in assessing the infection control programs. GAO also discovered that no other U.S. health care organization had up-to-date and specific guidance.

Working with an infection control expert and with representatives of nine organizations, including the Centers for Disease Control, GAO put together a list of 56 basic elements of an effective infection control program. GAO found that both VA and nonfederal infection control programs are using most of these elements. Several of GAO's infection control elements, however, should be used by more practitioners in both the public and private sectors. These elements—such as coursework in hospital infection control programs and reporting of surgical wound infection rates to practicing surgeons—are generally more labor intensive than those in widespread use. To be most effective, VA programs also need management attention. VA infection programs are generally understaffed, not coordinated at the central office, and inadequately monitored by regional offices.

VA Health Care: Assessment of Surgical Services at Two Medical Centers in the Southwest (GAO/HRD-90-6, Dec. 14, 1989)*

In 1985 VA told its medical districts to review the performance of medical centers and to identify services that should be consolidated or eliminated. In GAO's review, VA's decisions to close inpatient surgical services at the Prescott Medical Center in Prescott, Arizona, and to retain them at the Big Spring Medical Center in Big Spring, Texas, appear reasonable. VA considered many factors, including workload and availability of alternative locations for inpatient surgery. In both cases, veterans could receive needed surgical services at other medical centers; however, the burden imposed by closure was far greater for Big Spring area veterans than for Prescott area veterans.

VA Health Care: Better Procedures Needed to Maximize Collections From Health Insurers (GAO/HRD-90-64, Apr. 6, 1990)*

Each year VA spends about $10 billion on health care for veterans. Since 1986 VA has been able to collect from health insurers the cost of care provided to insured veterans. GAO found that collections so far have greatly exceeded costs. In fiscal year 1988, for example, VA spent about $8 million to collect about $100 million from health insurers. Yet GAO estimates that VA collected only about one-third of the total amount it could have collected.

GAO believes that VA centers could increase collections significantly if they (1) used more effective methods to identify insured veterans and bill insurers and (2) committed more resources to collection efforts. Centers are reluctant to make such a commitment for two reasons. First, all amounts collected must, by law, be returned to the U.S. Treasury. Second, the additional collection costs that centers incur are paid for out of their existing medical care budgets.

VA Health Care: Efforts to Assure Quality of Care in State Homes (GAO/HRD-90-40, Nov. 27, 1989)*

GAO found no basis to suggest that VA should require its medical centers to inspect state homes more frequently than it currently does (annually). GAO also found that VA has adequate procedures to assess the care state homes can provide. The procedures, however, were not always followed. In response to recommendations in a 1981 GAO report, VA revised its inspection guidelines to more closely conform to those used in HCFA's Medicare certification inspections. In addition, VA's central office now reviews all inspection reports to see that all standards have been addressed and that there are no omissions or clerical errors.

VA Health Care: Improvements Needed in Nursing Home Planning (GAO/HRD-90-98, June 12, 1990)*

VA faces a major challenge: how to meet the long-term care needs of a rapidly aging veteran population. The number of veterans 65 years and older is projected to grow to 9 million by 2000—a 50-percent increase over the 1988 level. VA's current goal is to provide 47,000 nursing home beds by fiscal year 2000, an increase of 14,000 beds over fiscal year 1988. GAO is concerned that because of inaccurate estimates, VA may add nursing home beds where they are not needed or fail to add them where they are needed.

VA Health Care: Medical Centers Need to Improve Collection of Veterans' Copayments (GAO/HRD-90-77, Mar. 28, 1990)*

VA is required to collect a fee, known as a copayment, from some veterans who receive health care at VA facilities. Unless they have a service-connected disability or there are special circumstances, veterans who have assets or income above a specified level must make the copayments.

GAO assessed whether VA's process for billing and collecting copayments is cost effective. Collections at VA's 159 medical centers exceeded costs, yielding a return of $1.36 for each $1 spent during fiscal year 1988. The centers' return for inpatient care was significantly higher than for outpatient care--$1.74 compared to $1.08.

The five medical centers GAO visited collected only about half of the copayments that veterans owed. This was mainly because the centers failed to bill these veterans. Some veterans, however, did not pay when billed. These bills were usually sent several weeks to months after care was provided, contributing to the centers' collection problems. GAO believes that VA centers need to improve their billing and collection practices in order to increase copayment collections and reduce collection costs. For instance, VA could follow the example of many private hospitals and collect from or make payment arrangements with patients before they leave the center.

VA Health Care: Nursing Issues at the Albuquerque Medical Center Need Attention (GAO/HRD-90-65, Jan. 30, 1990)*

GAO looked at several concerns—ranging from inadequate staffing and pay inequities to waste and loss of supplies and equipment—raised by nurses at the VA's medical center in Albuquerque, New Mexico. GAO found that management at the Medical Center has resolved many of these issues. Nurse vacancies and overtime have been reduced, pay issues have been addressed, the number of promotions and awards has increased, disciplinary actions have been reduced, the nursing home care unit is being renovated, and the number of beds operated in the facility has been reduced. In addition, VA has submitted a legislative proposal to the Office of Management and Budget that would address pay issues that cannot be handled at Center level.

While progress has been made in many areas, staff injuries, support services, paperwork, and acuity determinations need to be addressed more fully during the monthly meetings between management and the registered nurses' union. GAO believes an independent human resources specialist should be brought in to enhance the dialogue between the two groups. The medical center director also needs to actively participate in

the meetings. In addition to the labor-management issues, center management must improve its internal controls over property. To eliminate any inconsistencies, management also needs to reexamine the physical requirements it places on nursing hires and nurses returning to work after an injury.

VA Health Care: Veterans' Concerns About Services at Wilmington, Delaware, Center (GAO/HRD-90-55BR, Feb. 8, 1990)*

GAO looked into veterans' concerns about health care services at VA's Wilmington Medical Center. Concerns were expressed about cleanliness at the center and about delays in obtaining care in the following areas: outpatient orthopedics, pharmacy, prosthetics, cardiology, speech therapy, and diagnostic testing. In November 1989, GAO reported that steps had been taken to address concerns in the cardiology and diagnostic testing areas. Waiting times for speech therapy and prosthetics did not seem to be a problem. In this report, GAO concludes that the medical center and headquarters officials have taken reasonable steps to address veterans' concerns about orthopedic care, pharmacy services, outpatient care, and housekeeping services.

Veterans' Benefits: VA Needs Death Information From Social Security to Avoid Erroneous Payments (GAO/HRD-90-110, July 27, 1990)

Each year, VA provides billions of dollars in disability compensation and pension benefits to veterans and their surviving spouses. Benefits should end promptly when a beneficiary dies; however, if surviving relatives or others are slow in reporting a beneficiary's death, substantial payment errors can result.

GAO matched VA benefit payment files with death information kept by SSA and found that in April 1989, VA paid about $5.7 million to over 1,200 veterans who had been dead for at least 4 months; about 100 veterans had been dead for 10 years or more. GAO believes that VA and SSA need to establish a way to exchange information on deceased beneficiaries. Because many VA beneficiaries do not have social security numbers on file with VA, GAO recommends that the Congress authorize VA to require social security numbers of all veterans and their survivors as a condition of eligibility for VA compensation and pension benefits.

Other

Aging Issues: Related GAO Reports and Activities in Fiscal Year 1989 (GAO/HRD-90-56, Jan. 12, 1990)*

This report is a compilation of GAO's fiscal year 1989 work concerning older Americans. GAO looked at a wide range of issues—income security, health care, housing, nutrition, community and legal services, employment, and age discrimination among them. Appendixes in the report list the following types of GAO efforts: issued reports on policies and programs directed mainly at older Americans; issued reports on policies and programs in which the elderly were one of several target groups; testimony; ongoing activities; and other activities by GAO officials, like speaking engagements and publications. The report also notes that GAO policies prohibit age discrimination and that as of September 30, 1989, 54 percent of GAO's work force was 40 years of age or older.

Aviation Safety: Information on FAA's Age 60 Rule for Pilots (GAO/RCED-90-45FS, Nov. 9, 1989)*

GAO looked at the Federal Aviation Administration's (FAA) regulation—known as the "Age 60 Rule"—prohibiting individuals age 60 or over from piloting large commercial aircraft. This fact sheet provides information on (1) the history of the rule; (2) exemption requests, including the number filed and granted; (3) the number of "special issuance" medical certificates granted to air transport pilots under age 60; and (4) studies on the rule. A list of the major court cases identified by FAA involving the Age 60 Rule is also provided.

Older Americans Act: Administration on Aging Does Not Approve Intrastate Funding Formula (GAO/HRD-90-85, June 8, 1990)*

The U.S. District Court for the Southern District of Florida ruled in 1987 that Florida's formula for distributing federal grants provided under Title III of the Older Americans Act for supportive and nutrition services was invalid. The court found that the formula not only failed to consider the needs of low-income minorities but also contained factors that discriminated against minorities.

GAO reviewed each state's Title III intrastate funding formulas and found, among other things, 20 formulas that contain a factor that was found to discriminate against minorities in the Florida case. While HHS's Administration on Aging, which is responsible for administering the act, reviews and comments on states' funding formulas, the agency believes that the act does not authorize it to approve or disapprove formulas. GAO is concerned that some state formulas may be causing funds to be distributed contrary to the intent of the act and its regulations. As a

result, the Congress should consider clarifying whether the Administration on Aging should disapprove formulas the agency does not believe meet the intent of the act and its regulations.

Fiscal Year 1990 GAO Reports on Issues Affecting the Elderly and Others

GAO issued 41 reports in fiscal year 1990 on policies and programs in which the elderly were one of several target groups. Of these, 7 were on food assistance, 13 on health, 6 on housing, 8 on income security, 5 on veterans' issues, and 2 on other issues. An asterisk after the report title indicates that the review was performed at the request of Committees or Members of Congress. Two asterisks indicate that the work was mandated by statute. When no asterisks are noted, the work was undertaken as part of GAO's basic legislative responsibility to audit and evaluate federal agencies and programs.

Food Assistance

Food Assistance Programs: Recipient and Expert Views on Food Assistance at Four Indian Reservations (GAO/RCED-90-152, June 18, 1990)*

Indians on reservations receive food assistance primarily through the Food Stamp Program and the Food Distribution Program on Indian Reservations. This report provides the views of recipients and community officials on four reservations, collected through focus group interviews and panel discussions, regarding the (1) ability of Indians to participate in the programs, (2) impact of the programs on hunger and diet-related concerns on the reservations, and (3) adequacy of nutrition education provided by the programs.

According to the collective views of community officials, hunger exists on the four reservations. Hunger is more common among Food Stamp households than Food Distribution households because of program administrative hindrances and inadequate benefit levels. GAO also reported that recipients and community officials were concerned that the limited variety and poor quality of some Food Distribution Program foods and limited availability of nutrition education contribute to diet-related health problems, such as diabetes, obesity, hypertension, and heart disease.

Food Assistance: USDA's Implementation of Legislated Commodity Distribution Reforms (GAO/RCED-90-12, Dec. 5, 1989)

In recent years the commodity distribution program's goals of removing surpluses and providing a variety of nutritious foods to recipients has been in frequent conflict. The elderly, schools, and other recipients received quantities and kinds of food in a manner that increased storage and handling costs and hindered the effective use of the commodities. In response, the Congress mandated a broad range of 31 commodity distribution program reforms under the Commodity Distribution Reform Act and WIC Amendments of 1987 (P.L. 100-237). Sixteen of the reforms

had legislated implementation deadlines. GAO found that 6 of the reforms were implemented ahead of schedule, and 10 missed their mandated dates for a variety of reasons.

Food Stamp Program: A Demographic Analysis of Participation and Nonparticipation (GAO/PEMD-90-8, Jan. 19, 1990)*

Why do some households that are eligible for food stamps not receive them? GAO found that in 1987 over 56 percent of eligible households did not participate in the Food Stamp program. Households receiving other welfare benefits were more likely to participate in the Food Stamp program. On the other hand, households receiving Social Security, those headed by the elderly, and those headed by both white and nonwhite single men were less likely to receive Food Stamps. The main reasons given for not participating in the Food Stamp program were (1) lack of interest in the benefits, (2) lack of information about the program, and (3) problems with the program or lack of access to it. Given that outreach efforts may be resumed under the Hunger Prevention Act, GAO believes states should be encouraged to target those groups that would most benefit from the program.

Food Stamp Program: Achieving Cost Neutrality in Washington's Family Independence Program (GAO/RCED-90-84, June 28, 1990)*

Breaking the "cycle of poverty" of welfare recipients has always been a central, but elusive, goal of welfare reform. In 1987 the Congress authorized the state of Washington to begin a 5-year demonstration project—the Family Independence Program—that combines several welfare programs, including Aid to Families With Dependent Children, Medicaid, and Food Stamps, into a single grant package for recipients. The hope is that a coordinated approach may work better in reducing recipients' long-term dependence on welfare. However, the authorizing legislation for the program requires the state to ensure that the cash approach is not more costly than the traditional coupon program.

GAO found that the 1987 act's requirement for assurances of cost neutrality probably cannot be fully satisfied. Instead, a reasonable approximation of program costs is likely the best that can be achieved. The current approach is for the state to estimate how much it would have cost to run a traditional Food Stamp Program and to use this estimate as a ceiling for the amount of aid the state can claim from the federal government. Between July 1988 and March 1989, the state claimed $145.4 million for food benefit costs and administrative expenses, or about $2.5 million below the total allowed under the ceilings. GAO has several problems with the methods used to set the program's benefit and administrative ceilings. GAO believes that using alternative methodologies

could improve the accuracy of the calculations and better ensure that the cost-neutrality requirement is being met.

Food Stamp Program: Alternative Definitions of a Household for Food Stamp Eligibility (GAO/RCED-90-137, Aug. 23, 1990)*

Food stamp benefits are provided to households rather than to individuals; thus, a key factor in determining applicants' eligibility and benefits is how the household is defined. This report (1) describes how the definition of "household" evolved into its current complex form; (2) discusses whether the current definition contributes to homelessness in America; and (3) provides a range of alternative definitions and discusses their potential effects on participation and benefit payments, homelessness, and program simplicity.

Food Stamp Program: The Household Definition Is Not a Major Source of Caseworker Errors (GAO/RCED-90-183, July 26, 1990)*

Since food stamps are provided to households rather than to individuals, a key factor in determining an applicant's eligibility and benefits is how accurately caseworkers apply the household definition. The current definition of a food stamp household is complex, and state officials say that it is difficult to apply in computing food stamp benefits. However, GAO found that caseworkers made few mistakes and that applying the definition is not a major source of caseworker error; caseworkers nationwide made household definition errors in about 1 percent of the 80 million food stamp issuances in fiscal year 1988.

Food Stamp Automation: Some Benefits Achieved; Federal Incentive Funding No Longer Needed (GAO/RCED-90-9, Jan. 24, 1990)*

In fiscal year 1987, $10.5 billion worth of food stamps were distributed. About $1 billion of this was issued erroneously. To improve the program's administration and to combat rising costs, the Congress passed legislation in 1980 and 1985 encouraging automation of the food stamp program. State agencies have spent $524 million since 1980 toward this goal.

GAO looked at (1) statewide food stamp automation programs in Vermont, North Dakota, Kentucky, and Texas and (2) three local food stamp automation programs in Texas and California. While GAO found that these efforts have improved some administrative procedures and caseload management and have helped workers avoid or detect program errors made when program eligibility is decided on, automation has not yielded all of the expected benefits in program administration, such as staff reduction. Some of these goals were beyond the capability of the automated systems.

Although millions of dollars were approved for state automation, GAO could not always determine costs because the five state agencies did not keep adequate records on the expenses of developing and operating each automated system. Additionally, the U.S. Department of Agriculture's Food and Nutrition Service did not always monitor state claims for cost reimbursement, resulting in overpayments to at least one state. Not one of the five states could account for all of the automation equipment purchased with federal funds, thereby increasing the risk of waste, fraud, and abuse. Because food stamp programs in all 50 states, the District of Columbia, Guam, and the Virgin Islands are now automated to some degree, GAO believes the 75-percent funding level established by the Congress to encourage state automation is no longer needed.

Health

Defense Health Care: Potential for Savings by Treating CHAMPUS Patients in Military Hospitals (GAO/HRD-90-131, Sept. 7, 1990)*

Because of staff shortages, the military hospital system has considerable unused physical capacity, and beneficiaries are turning to civilian medical providers for health services. The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) picks up a major part of the tab for such treatment.

GAO found that the Department of Defense (DOD) can potentially save money by adding staff and equipment at military hospitals so they can treat more patients, rather than paying for their care under CHAMPUS. This conclusion tends to support expansion of military hospital capacity in the manner now being tested under several DOD health care initiatives. However, potential savings vary significantly by medical specialty and hospital; the savings could be great in some specialties and in some locations but negligible in others. GAO believes that DOD should identify facilities and specialties in which expansion of treatment capability is most likely to be cost-effective before it expands the current initiatives.

DOD Health Care: Funding Shortfalls in CHAMPUS, Fiscal Years 1985-91 (GAO/HRD-90-99BR, Mar. 19, 1990)*

GAO found that funding shortfalls for CHAMPUS have totaled $1.8 billion over the past five fiscal years; an additional $441 million funding shortfall is expected in fiscal year 1990. DOD projects no shortfall in fiscal year 1991 because of its efforts to reduce CHAMPUS costs.

In every year since 1986, DOD has requested less funds in its budget than it estimated the program was going to cost. These lower estimates have

been a major contributor to the yearly CHAMPUS funding shortfalls. In addition, each Congress appropriates less money than DOD requests. Unexpected start-up costs for the CHAMPUS Reform Initiative and the extension of CHAMPUS care to Coast Guard beneficiaries also contributed to shortfalls in some years. DOD estimates of future CHAMPUS costs rely on projected savings from efforts to accommodate more of the CHAMPUS workload in the direct care system. If these efforts are unsuccessful, DOD may continue to experience substantial shortfalls.

Health Care: Limited State Efforts to Assure Quality of Care Outside Hospitals (GAO/HRD-90-53, Jan. 30, 1990)*

Over the last 20 years, medical procedures that have traditionally been done in hospitals, like cardiac catheterization, blood testing, and radiation therapy, are increasingly being done in "freestanding" facilities. GAO looked at state licensing, inspection, and endorsement for 16 types of freestanding providers, including ambulatory surgical centers, cancer treatment centers, and hospice care.

GAO found that states have been slow to license freestanding providers and, in fact, do not license most of the 16 types of freestanding providers GAO focused on. Even when such providers are licensed, states have imposed few sanctions for deficiencies cited during inspections. Further, states' plans for expanding licensing requirements to unlicensed providers are limited. Because of minimal state regulatory efforts, consumers have little assurance that unlicensed freestanding providers are offering quality care.

Health Care: Public Health Service Funding of Community Health Centers in New York City (GAO/HRD-90-121, Aug. 7, 1990)*

To receive funding under section 330 of the Public Health Services Act, public community health centers must have community governing boards that conform to certain requirements. This report provides information on the following centers in New York City that receive grants from the Public Health Service: Montefiore Hospital and Medical Center/Ambulatory Care Network, Bronx-Lebanon Hospital Center/Ambulatory Care Network, Lutheran Medical Center/Sunset Park Family Health Center, and St. Mary's Hospital/Family Health Care Network.

GAO found that none of the four centers had governing boards that complied with federal regulations for the section 330 program. In each case, the Public Health Service gave the center a chance to meet the requirements. Three of the four grantees later complied with the regulations; the fourth decided to make no changes and did not apply for a continuation grant. GAO also discusses the share of section 330 funds that the

Public Health Service awarded to grantees in New York state during the 1980s.

Health Insurance: Cost Increases Lead to Coverage Limitations and Cost Shifting (GAO/HRD-90-68, May 22, 1990)*

Spiraling health care costs, growing competition from foreign firms, and basic changes in the health care marketplace have caused U.S. firms to reconsider the health care benefits they provide to their employees. For most full-time employees of larger companies, health benefits are still widely available. Nevertheless, even health benefits provided by some large firms are starting to erode. Companies are reassessing who and what are covered and how services are provided or insured. To reduce costs, firms have been limiting the number of people covered by their plans, hiring temporary or part-time workers who receive no health benefits, and limiting or eliminating retiree and dependent coverage. In addition, companies have been asking employees to pay a larger share of health care costs; introducing managed care or utilization review programs to reduce utilization of health care services; and, in the case of large firms, self-insuring. Self-insurance has frustrated state efforts to expand health care benefits through mandatory coverage requirements since employers that self-insure are exempt from these measures. Problems are more serious for small firms. Because of the relatively high costs for small firms, less than half of companies with 10 or fewer employees offer their workers health insurance. At the same time, insurance companies commonly deny health coverage to many of these employees because of preexisting health conditions.

Medicaid: Oversight of Health Maintenance Organizations in the Chicago Area (GAO/HRD-90-81, Aug. 27, 1990)*

Medicaid pays HMOs a fixed monthly amount per enrolled recipient to provide all health services covered by the program. Although this practice has the potential for containing health care costs, it also poses the danger of diminished quality of care should an HMO try to cut costs by reducing services to Medicaid recipients. A series of articles in the Chicago Sun Times alleging that Chicago-area HMOs had been providing poor care to Medicaid recipients prompted a GAO investigation of the situation.

GAO found that the incentive payment methods used by the largest Chicago-area HMOs to control use of health care services could jeopardize the quality of care provided to Medicaid recipients. Under the current payment system, physicians can be forced to pay the cost of some care out of pocket if the cost of patient care exceeds the amount they are paid to care for the patients. GAO is concerned that physicians could find themselves in situations (1) in which they might have to make decisions

on patient care that could cost them money or (2) that would result in inappropriate reductions in services. GAO believes that stronger HMO management controls are needed in the Chicago area to help identify and prevent physician behavior that could harm the quality of care.

Mental Health Plans: Many States May Not Meet Deadlines for Plan Implementation (GAO/HRD-90-142, Sept. 18, 1990)**

GAO is required to evaluate states' implementation of the State Comprehensive Mental Health Services Plan Act of 1986 and report on that evaluation by September 30, 1990. This law requires states to plan and implement community-based care for their seriously mentally ill. It also directs the HHS to provide planning assistance. While GAO concludes that it is too soon to fairly and adequately assess implementation because states are not required to fully implement their plans until September 1991, GAO did examine state planning activities and assessed the National Institute of Mental Health's (NIMH) role in helping states develop plans.

GAO found that the states and NIMH have complied with the act's planning requirements. In addition, the act has achieved beneficial results, like greater involvement by the mentally ill, their families, and advocates in mental health planning, as well as more money for community mental health services. However, many states may have difficulties in meeting the act's implementation deadlines and, as a result, may be subject to cuts in block grant allotments in fiscal years 1991 and 1992.

Medical Device Recalls: Examination of Selected Cases (GAO/PEMD-90-6, Oct. 19, 1989)*

This report contains more descriptive analyses and profiles based on the data GAO collected for its August 1989 report (see GAO/PEMD-89-15BR). GAO did further analyses on two types of recalls: (1) those involving medical devices that the Food and Drug Administration (FDA) had approved for marketing through its premarket approval process (PMA) and had later recalled for design problems and (2) those that FDA classified as posing the most serious health risk (class I). GAO found 28 PMA-design and 48 class I recalls between fiscal years 1983 and 1988. These recalls, although accounting for only about 4 percent of all recalls for the period, have the most serious public health implications. Design problems were the most frequent reason for both PMA-design recalls and class I recalls. While no adverse health consequences were associated with the majority of PMA-design recalls or with 42 percent of the class I recalls, about one-third of the PMA-design recalls and over half of the class I recalls were associated with at least one patient's injury or death. There is no requirement that device manufacturers notify FDA of recalls,

and GAO found that in many cases the agency was unaware of the recall until after it had started or even until it had been completed.

On the basis of the data presented in this report, GAO believes additional study of potential vulnerabilities in FDA's medical device premarketing approval and recall process is needed. Questions have been raised about the number of device recalls that remain unknown to FDA and about the timeliness of recall actions taken by FDA and manufacturers. When FDA was making critical decisions about recalls, reports of device problems had not been filed on nearly two-thirds of PMA-design and almost half of the class I recalls. As a result, the effectiveness of the medical device reporting regulation as an "early warning" of medical device problems is questionable. In testimony before the Congress, GAO summarized the findings of its two medical devices recall reports.

Military Health Care: Savings to CHAMPUS From Using a Prospective Payment System (GAO/HRD-90-136FS, July 13, 1990)*

This fact sheet details GAO's analysis of a prospective payment system—under which covered medical expenses are paid according to a predetermined rate schedule rather than according to hospital charges—adopted by the Civilian Health and Medical Program of the Uniformed Services. The prospective payment system is modeled on that used by Medicare and is designed to reduce government health care costs and to encourage hospitals to reduce their operating costs.

Minority Health: Information on Activities of HHS's Office of Minority Health (GAO/HRD-90-140FS, June 6, 1990)*

HHS Office of Minority Health was created in 1985 to focus on the health problem needs of minority groups, a fast-growing segment of the U.S. population. This fact sheet examines the Office's goals and objectives, funding, staffing, and program activities.

Nonprofit Hospitals: Better Standards Needed for Tax Exemption (GAO/HRD-90-84, May 30, 1990)*

Because of increasing pressure to contain costs, are some hospitals reducing indigent care and other charitable activities? Nonprofit hospitals have come under special scrutiny recently because of their preferred treatment as charities under the tax code. In the five states GAO reviewed—California, Florida, Iowa, Michigan, and New York—government-owned hospitals provided a disproportionate amount of uncompensated care, whereas both nonprofit and for-profit hospitals provided a smaller share of the states' uncompensated care. The burden of uncompensated care was not spread equally among the nonprofit hospitals in these five states. Large urban teaching hospitals had a higher

share of the uncompensated care expense than did other nonprofit hospitals. Among the rest of the nonprofit hospitals, the tendency was for those with the highest operating margin (and, therefore, the greatest ability to finance charity care) to have the lowest rates of uncompensated care. About 80 percent of the nonprofit hospitals in these states reported total uncompensated care costs in excess of GAO's estimate of the value of their federal tax exemption. However, GAO found that in some states a far lower percentage incurred charity care costs in excess of GAO's estimate of the value of their tax exemption: 71 percent in New York and only 43 percent in California. GAO believes that if Congress wishes to encourage nonprofit hospitals to provide charity care and other community services, it should consider revising the criteria for tax exemption.

Quality Assurance: A Comprehensive National Strategy for Health Care Is Needed (GAO/PEMD-90-14BR, Feb. 21, 1990)*

How can the quality of health care be ensured under plans to expand health care coverage for the uninsured? GAO assembled a panel of eminent health policy researchers to address this question. The panel expressed the need for a national strategy for assessing and assuring the quality of health care. The panel viewed the following four elements as essential to a comprehensive national strategy: (1) national practice guidelines and standards of care; (2) enhanced data to support quality assurance activities; (3) improved approaches to quality assessment and assurance at the local level; and (4) national focus for developing, implementing, and monitoring a national system.

Rural Hospitals: Factors That Affect Risk of Closure (GAO/HRD-90-134, June 19, 1990)*

GAO found that closed rural hospitals tended to suffer substantial and increasing losses during the three years before they closed. Their losses were due primarily to their high cost per case relative to other, similar hospitals. Except for the smallest hospitals, losses on Medicare patients were less than losses on other patients. Contrary to popular perception, a hospital's location in a rural rather than an urban area did not increase its risk of shutting down. Rather, the factors that were associated with a higher risk of closure were low occupancy, small size, and ownership by a for-profit entity, which are more prevalent in rural areas. This suggests that strategies for preventing rural closures should target hospitals with high-risk factors rather than all rural hospitals.

Housing

Assisted Housing: Rent Burdens in Public Housing and Section 8 Housing Programs (GAO/RCED-90-129, June 19, 1990)*

Under federal housing law, assisted households are usually required to pay 30 percent of their adjusted income for rent. By regulation, the Department of Housing and Urban Development (HUD) has interpreted "rent" to include shelter cost plus a reasonable amount for utility costs. This interim report looks at the proportion of income that assisted households pay for rent and utilities (called "rent burden") at six public housing agencies.

Homelessness: Changes in the Interagency Council on the Homeless Make It More Effective (GAO/RCED-90-172, July 11, 1990)*

GAO found that the Interagency Council on the Homeless has made significant changes in response to March 1989 congressional hearings. At those hearings, GAO testified that the Council had been slow to respond to what the Congress had characterized as an immediate and unprecedented homelessness crisis. In this report, GAO notes that the leadership of the Council's current chairman—the Secretary of HUD—has improved substantially. For example, by loaning 10 HUD employees to serve as the Council's regional coordinators on a nonreimbursable basis, the Chairman has strengthened the Council's field coordination efforts and has improved services to the homeless. About two-thirds of the state officials and local assistance providers GAO surveyed said that the current Council's improvement efforts were "somewhat" to "very effective." These individuals also thought that the Council should be reauthorized to continue coordinating these efforts. GAO found the Council's 1989 annual report to the Congress to be better than last year's publication because it focuses on the federal response to the homeless and addresses the levels of federal funding needed to combat the problem of homelessness.

Homelessness: McKinney Act Programs and Funding for Fiscal Year 1989 (GAO/RCED-90-52, Feb. 16, 1990)**

GAO is required to report annually on the status of programs authorized under the McKinney Act. The act, which seeks to establish a comprehensive program to help homeless people, now funds 18 programs that provide direct services for the homeless. This report outlines the act's legislative history; describes each of the act's programs; and details monies provided under each program, by state, for fiscal year 1989. Of the $1.1 billion that the Congress appropriated for McKinney Act programs in fiscal years 1987 through 1989, the largest portion—around

$365 million—went to the Federal Emergency Food and Shelter Program, which gives food and shelter to needy people on an emergency basis.

Homelessness: McKinney Act Reports Could Improve Federal Assistance Efforts (GAO/RCED-90-121, June 4, 1990)*

This report describes the status of reports on programs for the homeless mandated by the McKinney Act. The act requires seven federal agencies and the Interagency Council on the Homeless to submit reports to the Congress on homelessness. Sixteen of the reports are a onetime requirement; 10 are required annually; and 1, a General Services Administration report meant to identify available surplus federal property for use by the homeless, is required quarterly. As of April 1990, 6 of the 16 onetime reports and 8 of the 10 annual reports for fiscal year 1988 had been issued.

GAO believes that these reports could give federal agencies and the Congress useful information on the effectiveness of programs in areas like housing and health care for the homeless. This information could be especially useful to the Congress as it considers reauthorization of the McKinney Act, which expires on September 30, 1990. However, each time that GAO has checked on overdue reports, HUD and HHS officials have changed the report issuance dates. Accordingly, it is important that these agencies brief the appropriate congressional committees on information contained in the reports. Further, these agencies need to work with the committees to establish new schedules for final reports.

Homelessness: Too Early to Tell What Kinds of Prevention Assistance Work Best (GAO/RCED-90-89, Apr. 24, 1990)**

Although no reliable national data exist, estimates of the homeless population in the United States range from 250,000 to 3 million. An even greater number may be at risk of becoming homeless due to eviction or mortgage foreclosure. Hundreds of state and local groups provide homelessness prevention assistance. Yet GAO could not determine the effectiveness of this assistance because few assistance providers have the resources to collect the client follow-up data needed for such evaluations. Prevention assistance usually takes the form of one-time rent, mortgage, or utility payments. Counseling may also be involved. While at least six federal programs provide funds in support of these efforts, state and local organizations decide whether to use funds for homelessness prevention or other assistance, like emergency food and shelter for those who are already homeless. Even though many groups provide homeless prevention aid, the demand for their help is so great that some programs have run out of money or have had to cut back their assistance to individuals. GAO believes that collecting and evaluating data on

the different types of assistance would help groups to target their limited resources to the most effective programs.

Rental Housing: Observations on the Low-Income Housing Tax Credit Program (GAO/RCED-90-203, Aug. 14, 1990)*

The Low-Income Housing Tax Credit Program—authorized in the Tax Reform Act of 1986—was intended to provide an incentive for investors to construct or rehabilitate low-income housing. This report provides information on the following: (1) the estimated cost to the Treasury of low-income housing tax credits awarded during 1987-89, (2) whether the awarded tax credits have resulted in reduced rents paid by tenants in credit-assisted units, (3) whether such tenants have been selected from waiting lists maintained by public housing authorities, (4) the adequacy of existing compliance monitoring requirements, (5) the adequacy of current statutory provisions designed to prevent noncompliance, and (6) alternative tax credit allocation formulas.

Income Security

Disability Programs: Use of Competitive Contracts for Consultative Medical Exams Can Save Millions (GAO/HRD-90-141, Aug. 17, 1990)

Under SSA's disability programs, medical examinations of claimants seeking benefits are purchased when claimants' medical evidence is insufficient for disability determinations. State disability determination services, which SSA reimburses for 100 percent of those consultative examination costs, choose medical providers to do these examinations and determine the examination payments. Data on DDSs from New York and Oregon show substantial savings in consultative examination costs when competitively awarded contracts are used. GAO believes that SSA should work closely with state DDSs to identify areas in which competitively awarded contracts are feasible and to require their use, where appropriate, because of the potential for annual savings of millions of dollars.

Information Resources: Management Commitment Needed to Meet Information Challenges (GAO/IMTEC-90-27, Apr. 19, 1990)

As part of its ongoing general management review, GAO evaluated information resources management at VA. GAO found that top managers at VA do not have information readily available to assess the quality of health care or the effectiveness of services provided to veterans. VA information is contained in over 150 fragmented automated systems and in multiple, ad hoc manual systems. The information is neither efficiently collected nor easily accessed. These weaknesses have hindered VA's ability to effectively manage programs and have contributed to service

delays. Because VA lacks a structured approach to systematically plan, prioritize, and implement its near- and long-term information needs, the agency cannot effectively evaluate its own performance and fix accountability. Individual agency components—medical, benefits, and national cemetery—have striven to automate and improve technology, but their autonomy hinders development of an integrated information resources management program at VA. Further, VA has not sufficiently developed or implemented policies to foster systems' integration and data sharing. VA has started to correct these deficiencies by streamlining its central information resources management organization and by developing a process that would include strategic planning. But remaining challenges will require continued VA commitment and support.

Pension Benefits: Processing of Applications by the Pension Benefit Guaranty Corporation (GAO/HRD-90-127, Sept. 25, 1990)*

GAO reported to the Congress on four cases involving pension benefit applications processed by the Pension Benefit Guaranty Corporation (PBGC). Established by the Employee Retirement Security Act of 1974 (ERISA), PBGC administers an insurance program that guarantees participants' earned benefits at plan termination. PBGC insures nearly 40 million workers in approximately 102,000 private pension plans. Two of the cases reviewed by GAO involved denials of benefits that were subsequently reversed. GAO concurred with the reversals. In the third case, GAO agreed that denial of benefits was warranted. In the fourth case, GAO determined that IRS's delays in processing requests for information were causing delays in benefit payments to PBGC plan participants. IRS subsequently revised its policy to ensure that PBGC receives requested information within 90 days.

Social Security Disability: Denied Applicants' Health and Financial Status Compared With Beneficiaries' (GAO/HRD-90-2, Nov. 6, 1989)**

The Social Security Disability Insurance Program is the main source of income replacement for the nation's workers who cannot work because of disabling health conditions. Each year, about 1 million people apply for benefits and about 30 percent are awarded them. Overall, GAO found that both Social Security disability beneficiaries and denied applicants are not well-off in terms of employment, health, and financial status. Almost all of the applicants who were allowed Social Security disability benefits in 1984 said they were not working at the time of GAO's survey in 1987. Over half of the applicants who were denied benefits during the same period also reported not working. In general, the self-reported health status of denied applicants as a group was slightly better than that of the allowed population. However, when separating the denied applicants into those who were working and those who were not, GAO

found that the health status reported by the nonworking denied applicants resembled that of allowed applicants; both were significantly worse than that of denied applicants who were working. As of 1987, about two-thirds of former beneficiaries who had been determined by SSA, between 1981 and 1984, to be ineligible for benefits had been reinstated on the benefit rolls. Of those who remained ineligible, over half had returned to work, but many had no health insurance.

Social Security: Resolving Errors in Wage Reporting (GAO/HRD-90-11, Oct. 17, 1989)*

GAO examined SSA's efforts to reconcile cases in which employers reported lower amounts of wages to SSA than to IRS. GAO found that SSA has been able to reconcile some cases by telephone that it had been unable to reconcile by its usual method—by mail. SSA's telephone success rate, however, was much less than that initially estimated by two internal studies. This was because the study samples provided unreliable estimates and because the resolution of some cases was incorrectly attributed to telephone reconciliation rather than to other SSA activities. SSA now telephones employers only if wage-reporting differences are at least $500,000—an arbitrary threshold.

However, GAO's work indicates that SSA could increase the chances of obtaining previously unreported wage information by devoting more effort to reaching employers (1) whose whereabouts are known to SSA and (2) who had recently submitted wage reports to SSA indicating that they were still in business and might have information needed to resolve the reporting problem. This could improve SSA's success rate and reconcile some cases below the current $500,000 threshold without increasing SSA's commitment of resources.

Social Security: Direct Mail Solicitations by the Social Security Protection Bureau (GAO/HRD-90-9, Jan. 26, 1990)*

The Social Security Protection Bureau is a private organization that offers to obtain earnings and benefit information from SSA and to lobby Washington on members' behalf. The bureau's benefits, however, have been criticized as dubious. For example, while people paying the $7 membership fee are helped in obtaining earnings information from SSA, this information is available from the government free of charge.

GAO's report contains information on (1) the income of the parent firm—the Watson & Hughey Company—and its organizational links with the bureau and other affiliated organizations; (2) bureau services; (3) bureau operations and their legality under federal laws; and (4) miscellaneous information, including the costs incurred by SSA and actions being considered or taken by state governments against the bureau.

Social Security: IRS Data Can Help SSA Credit More Wages (GAO/HRD-90-112, Aug. 31, 1990)

Each year, employers report to SSA the wages paid to their employees on form W-2. SSA then credits the wages to each worker's social security account. As of June 1989, however, about 178 million wage reports worth about $138 billion of uncredited earnings were recorded in SSA's suspense file. Over the past 5 years, the file has grown by $58.2 billion, or 73 percent.

GAO believes that SSA could reduce the size of the suspense file and credit more workers' wages by using independently developed IRS data to identify to whom the uncredited earnings belong. About one-third of the resolutions could be almost immediately credited to valid accounts with little cost to SSA. The remaining resolutions would require further research efforts, but the IRS data should provide SSA with a good starting point.

Social Security: Taxing Nonqualified Deferred Compensation (GAO/HRD-90-82, Mar. 15, 1990)*

In this report, GAO looks at whether self-employed taxpayers use deferred income arrangements that achieve similar income tax treatments as plans called "nonqualified deferred compensation plans" used by employers and employees. These nonqualified plans are basically employer IOUs to pay employees future benefits in return for current services. GAO also looks at how the imposition of the social security tax on employees using these kinds of plans differs from its imposition on self-employed taxpayers for similar types of income.

Veterans

Management of VA: Implementing Strategic Management Process Would Improve Service to Veterans (GAO/HRD-90-109, Aug. 31, 1990)

With an annual budget of about $30 billion, the Department of Veterans Affairs provides a range of services to America's veterans, including medical, housing, insurance, education, income, and burial assistance. Through affiliation with medical schools and support of research that benefits veterans' health care, VA also educates and trains many of the nation's medical practitioners. VA faces many challenges today, chief among them outdated VA medical facilities and a swiftly aging veteran population. GAO's management review (1) identifies lessons learned from past VA departmentwide strategic management processes and (2) develops a flexible secretarial-level strategic management process that could be adapted to VA.

Veterans' Compensation: Medical Reports Adequate for Initial Disability Ratings but Need to Be More Timely (GAO/HRD-90-115, May 30, 1990)*

GAO's review of veterans' initial claims for disability compensation showed that (1) VA regional offices requested medical examinations for the appropriate medical impairment and (2) the medical reports addressed all claims for compensation made by veterans. The medical reports contained diagnoses that were adequately supported by clinical tests and procedures and physical examinations done by VA physicians. With few exceptions, these reports provided enough medical evidence to allow VA medical and nonmedical rating board specialists to judge the extent of a veteran's disability and assign disability ratings for compensation. On the other hand, medical reports often do not meet VA timeliness standards.

VA Health Care: Delays in Awarding Major Construction Contracts (GAO/HRD-90-91, Apr. 5, 1990)**

VA's appropriation for fiscal year 1989 contained funding for 18 major construction projects, each estimated to cost $2 million or more. The appropriation required that (1) working drawing contracts for these projects be awarded by September 30, 1989, and (2) construction contracts be awarded by September 30, 1990. VA's appropriation for fiscal year 1988 contained funding for 15 other projects for which construction contracts were to be awarded by September 30, 1989. VA is required to inform the Congress and GAO of the projects that did not meet these time limits.

GAO believes that VA's February 1990 letter to congressional committees and to the Comptroller General includes all projects that were required to, but did not, have working drawing or construction contracts awarded by September 30, 1989. GAO also believes the contracting delays for the 17 construction projects included in VA's letter do not constitute an impoundment of budget authority under the Impoundment Control Act. VA's actions show no intent to refrain from using the funds. VA officials attributed the delays to several programmatic considerations, including changes in the projects' scope or design and receipt of bids that exceeded the funds available. VA has awarded or expects to award contracts for 14 of the 17 projects by September 30, 1990.

Veterans' Benefits: Improved Management Needed to Reduce Waiting Time for Appeal Decisions (GAO/HRD-90-62, May 25, 1990)*

During fiscal year 1989, VA paid about $15 billion for disability benefits and processed about 700,000 initial or reopened claims for these benefits. About 60,000 veterans appealed the decisions on their claims. However, in 1989 the average processing time for appeals decided by the Board of Veterans Appeals was 463 days—an increase of 44 days, or 11 percent, over 1988. Such untimely appeals delay financial, medical, and other benefits to which veterans are entitled. GAO found that improved management could reduce appeal processing time. This report details the management weaknesses identified.

Veterans' Benefits: VA Acts to Improve Quality Control System (GAO/HRD-90-161BR, Sept. 24, 1990)*

This briefing report discusses actions taken by VA in response to recommendations made in an April 1989 GAO report. These recommendations involve the statistical quality control system that VA runs for compensation, pension, and burial programs. GAO found that VA has fully implemented the recommendations. VA now requires regional offices to select sample cases randomly for system reviews and to review cases for the same month they are selected. In addition, VA has improved the central office role by (1) having its reviews to validate regional system reviews cover the same time period and types of processing actions as the regional reviews and (2) enforcing regional office compliance with central office requirements to report corrective action planned or taken for periods of sustained unacceptable quality. As recommended, VA has also developed measures of claims-processing quality for individual programs. VA is taking steps to respond to two other recommendations.

Other

Low-Income Home Energy Assistance: Legislative Changes Could Result in Better Program Management (GAO-HRD-90-165, Sept. 7, 1990)**

Under the Low-Income Energy Assistance Program (LIHEAP), states assist eligible households in meeting costs associated with home heating and cooling needs. Heating assistance makes up over 75 percent of program expenditures. GAO identified two issues concerning LIHEAP funding that suggest a need for possible congressional action to help HHS and the states better manage this program. First, use of a forward funding arrangement would make LIHEAP funds available in time to allow HHS to tell states exactly how much money they would receive before they open their winter heating programs. Second, providing for some discretionary funding flexibility would enable HHS to quickly respond to unanticipated increases in home heating costs due to severe weather or a sharp rise in fuel prices.

Management of HHS: Using the Office of the Secretary to Enhance Departmental Effectiveness (GAO/HRD-90-54, Feb. 9, 1990)

Secretaries of HHS shoulder responsibilities for budgets totaling hundreds of billions of dollars, for hundreds of programs, and for decisions that affect the health and welfare of millions of Americans. This management review of HHS concludes that the lack of an effective management system within the Office of the Secretary has hampered the ability of HHS Secretaries to manage their tremendous responsibilities. GAO believes such a system should help Secretaries understand and identify emerging policy and management issues, establish clear goals and objectives for these issues, and develop strategies to accomplish the goals and objectives. The system must also include accountability dimensions that enable the Secretary to monitor and track the Department's progress in achieving its goals and objectives, oversee the operation of programs and activities that have been delegated to others, and provide feedback to, and communicate with, the Department's components.

Fiscal Year 1990 Testimony Relating to Issues Affecting the Elderly

GAO testified 35 times before congressional committees during fiscal year 1990 on issues relating to older Americans. Of the testimonies, 4 were on food assistance issues, 14 on health issues, 5 on housing issues, 9 on income security issues, 1 on a social services issue, and 2 on veterans' issues.

Food Assistance

Adequacy of Nutrition Programs on Indian Reservations, by Flora H. Milans, Associate Director for Food and Agriculture Issues, before the Senate Committee on Agriculture, Nutrition and Forestry and before the Senate Select Committee on Indian Affairs (GAO/T-RCED-90-30, Feb. 20, 1990)

GAO testified on its findings regarding the Department of Agriculture's food assistance programs. While the Food Stamp program along with commodity foods have helped improve the diet of Indians, GAO found evidence of hunger on the four reservations it visited. Indians attributed the hunger to (1) obstacles in applying and qualifying for food stamps, (2) heavy reliance on federal programs that are not intended to provide a full diet for most households, (3) procedural requirements of the Food Stamp program that influence the size and delivery of benefits, and (4) high food prices that erode the purchasing power of food stamp benefits. Of greater concern to those GAO spoke with is the prevalence of diet-related problems like obesity, diabetes, heart disease, and hypertension. Even healthy individuals have concerns about the limited variety and poor quality of some commodity foods; for participants with diseases that require special diets, these foods can present serious problems. GAO believes better access to food assistance, an adequate and nutritious diet, and proper nutrition education could improve the quality of life on the reservations.

GAO Audit of the Food Stamp Program, by John W. Harman, Director of Food and Agriculture Issues, before the Subcommittee on Domestic Marketing, Consumer Relations, and Nutrition, House Committee on Agriculture (GAO/T-RCED-90-10, Oct. 31, 1989)

In this testimony, GAO discusses its past and present work on (1) food stamp automation, (2) alternatives to the current definition of a food stamp household, and (3) ways to improve the benefit opportunities for people eligible for the Food Stamp program.

GAO Audits of the Commodity Food Area, by John W. Harman, Director of Food and Agriculture Issues, before the Subcommittee on Domestic

Marketing, Consumer Relations, and Nutrition, House Committee on Agriculture (GAO/T-RCED-90-15, Nov. 15, 1989)

GAO testified on the commodity food area, which is administered by the Department of Agriculture's Food and Nutrition Service. GAO discussed its recent work on (1) the commodity distribution program reform mandated by 1987 legislation and (2) the commodity food distribution program at four Indian reservations. GAO found that USDA has implemented all of the legislated reforms, although some of the statutory implementation time frames were missed because of the lengthy review and approval procedures, the complexity of the reforms, and the law's broad application. GAO concluded that the Food Stamp program, along with commodity foods and nonfederal food assistance, has improved the diet of Indians living on or near the reservations. However, during its work, GAO was told by tribal officials about hunger at two of the reservations and GAO found a prevalence of diet-related diseases, such as diabetes, heart disease, and hypertension. GAO concludes that an adequate food supply and nutrition education could help improve the quality of life for Indians on these reservations.

Views on Temporary Emergency Food Assistance Program and Commodities for Soup Kitchens, by John W. Harman, Director of Food and Agriculture Issues, before the Senate Committee on Agriculture, Nutrition, and Forestry (GAO/T-RCED-90-69, Apr. 18, 1990)

This statement for the record contains information GAO gathered on the effectiveness of two programs extended or authorized by the Hunger Prevention Act of 1988—USDA's Temporary Emergency Food Assistance Program and a new program to provide commodities to soup kitchens or food banks. In summary, USDA and state officials told GAO that USDA's management of commodity purchases seems to be working effectively after program start-up delays. Recipient agency officials said they were generally satisfied with the amounts, types, and delivery schedules of the commodities received. GAO lists suggestions by state and local officials, as well as by recipients, for improving the programs.

Health

Employee Benefits: Trends in Retiree Health Coverage, by Joseph F. Delfico, Director of Income Security Issues, before the Subcommittee on Retirement Income and Employment, House Select Committee on Aging (GAO/T-HRD-90-51, July 27, 1990)

Company-sponsored health plans are a main source of health care coverage for retirees. This health care coverage is especially important to retirees under age 65 because most are ineligible for Medicare. Out of an estimated 96 million private sector workers, about two-thirds lack retiree health coverage. For the other one-third of the work force with such benefits, GAO testified that the security of company-sponsored retiree health plans is in question. GAO estimates that since 1984, fewer than 1 percent of companies have terminated retiree health benefits. However, at an increasing rate, companies have been shifting costs to retirees or reducing benefits. Retirees now receiving health benefits and active workers who expect to receive these benefits upon retirement currently have few legal protections from corporate cost cutting. GAO believes that the Congress may have to take explicit action if it wants to preserve company-sponsored retiree health benefits.

HCFA Needs Better Assurance That Hospitals Meet Medicare Conditions of Participation, by David P. Baine, Director of Federal Health Care Delivery Issues, before the Subcommittee on Health, House Committee on Ways and Means (GAO/T-HRD-90-44, June 21, 1990)

HCFA relies on the Joint Commission on Accreditation of Healthcare Organizations to identify and resolve problems in hospitals serving Medicare patients. However, HCFA lacks assurances that the hospitals surveyed by the Joint Commission are complying with Medicare requirements. While HCFA is unsure of the extent to which it can direct the Joint Commission to change its accreditation process to meet HCFA's needs, GAO believes that HCFA should try to guide the Joint Commission to ensure that hospitals meet Medicare requirements. If such efforts are unsuccessful, alternatives to the present system of accreditation can be considered. However, because none of the alternatives appears to be clearly superior to the present system, GAO discusses several different options for improving the system.

Long-Term Care Insurance: Proposals to Link Private Insurance and Medicaid Need Close Scrutiny, by Lawrence H. Thompson, Assistant Comptroller General for Human Resources Programs, before the Subcommittee on Health and the Environment, House Committee on Energy and Commerce (GAO/T-HRD-90-55, Sept. 14, 1990)

Several state demonstration projects have been proposed to coordinate private long-term care insurance with Medicaid. The goal of the projects is to see whether the promotion of long-term care insurance for the elderly will yield long-term care protection without increasing public

sector costs. Although the projects vary significantly, most propose allowing people who buy a qualifying private long-term policy to become Medicaid-eligible after the policy pays for a period of long-term care costs. Participants would not have to "spend down" or deplete as much of their savings as is now required to meet Medicaid eligibility thresholds. GAO believes that the proposed projects could reduce the financial hardships that some elderly endure as a result of catastrophic long-term care costs. On the other hand, risks would be involved if the projects are given authority to link private insurance coverage with Medicaid.

Medical Devices: The Public at Risk, by Charles A. Bowsher, Comptroller General of the United States, before the House Committee on Energy and Commerce (GAO/T-PEMD-90-2, Nov. 6, 1990) and

Medical Devices: Underreporting of Problems, Backlogged System, and Weak Statutory Support, by Eleanor Chelimsky, Assistant Comptroller General for Program Evaluation and Methodology, before the House Committee on Energy and Commerce (GAO/T-PEMD-90-3, Nov. 6, 1990)

GAO analyzed two types of recalls: (1) those involving medical devices that FDA had approved for marketing through its premarket approval process and had later recalled for design problems and (2) those that FDA classified as posing the most serious health risk (class I). GAO found 28 PMA-design and 48 class I recalls between fiscal years 1983 and 1988. These recalls, although accounting for only about 4 percent of all recalls for the period, have the most serious public health implications. Design problems were the most frequent reason for both PMA-design recalls and class I recalls. Although no adverse health consequences were associated with the majority of PMA-design recalls or with 42 percent of the class I recalls, about one-third of the PMA-design recalls and over half of the class I recalls were associated with at least one patient's injury or death. There is no requirement that device manufacturers notify FDA of recalls, and GAO found that in many cases the agency was unaware of the recall until after it had started or even until it had been completed.

On the basis of these data, GAO believes additional study of potential vulnerabilities in FDA's medical device premarketing approval and recall process is needed. Questions have been raised about the number of device recalls that remain unknown to FDA and about the timeliness of recall actions taken by FDA and manufacturers. When FDA was making critical decisions about recalls, reports of device problems had not been filed on nearly two-thirds of PMA-design and almost half of the class I

recalls. As a result, the effectiveness of the medical device reporting regulation as an "early warning" of medical device problems is questionable.

Medicare: Effects of Budget Reductions on Contractor Program Safeguard Activities, by Janet L. Shikles, Director of Health Financing and Policy Issues, before the Subcommittee on Health, House Committee on Ways and Means (GAO/T-HRD-90-42, June 14, 1990)

How vulnerable is the Medicare program to waste, abuse, and mismanagement? GAO focused on the insurance companies that contract with the government to process and pay claims for Medicare-covered services. In recent years, the funding available for carrying out claims processing and payment safeguard activities has not kept pace with the growth of the program. GAO testified that the ability of Medicare contractors to ensure the accuracy of program payments has deteriorated seriously. In GAO's view, attempting to save administrative costs by reducing funding for payment safeguard activities is penny-wise and pound-foolish because safeguards tend to save the Medicare trust fund $11 for every $1 spent. GAO believes that increased funding is needed in this area.

Medicare: GAO Views on Medicare Payments to Health Maintenance Organizations, by Janet L. Shikles, Director of Health Financing and Policy Issues, before the Subcommittee on Health, House Committee on Ways and Means (GAO/T-HRD-90-27, May 8, 1990)

When it enacted Medicare's current HMO risk-contract payment system, the Congress intended both to offer an HMO option to a wider set of Medicare beneficiaries and to save Medicare program funds. The fixed payment amount for Medicare HMO enrollees was intended to be, on average, 5 percent less than the expected Medicare cost if the enrollees had remained in the fee-for-service sector. GAO is concerned that increasing the payment rate from 95 to 100 percent of the adjusted average per capita cost would eliminate any potential for savings. There was also concern in the Congress that inaccuracies in the adjusted average per capita cost could lead to excessive payments to HMOs.

In GAO's view, this concern seems well founded in light of recent studies that concluded that Medicare beneficiaries enrolled in HMOs are healthier and tend to use fewer health care services—and are thus on average less costly to treat—than non-HMO beneficiaries. The studies also found that the methodology used to calculate the adjusted average per capita cost does not accurately reflect these cost differences. Therefore, rather

than paying less, Medicare may have paid HMOs more than if the same enrollees had remained in the fee-for-service sector. In addition, GAO found serious problems in the way HCFA had implemented the payment safeguard mechanism—the adjusted community rate—intended to ensure that HMOs do not receive windfall profits from inaccuracies in the adjusted average per capita cost process.

Medigap Insurance: Expected 1990 Premiums After Repeal of the Medicare Catastrophic Coverage Act, by Janet L. Shikles, Director of Health Financing and Policy Issues, Before the Senate Special Committee on Aging (GAO/T-HRD-90-9, Jan. 8, 1990)

The Congress repealed the Medicare Catastrophic Coverage Act in November 1989. As a result, private insurance—known as Medigap policies—must now provide benefits that insurers did not expect to provide in 1990. GAO surveyed 29 commercial Medigap insurers, each with at least $10 million in earned premiums or Medigap policies in 1987. The 20 insurers that responded said they expected to raise their 1990 Medigap insurance premiums by an average of 19.5 percent. The companies attributed about half of this increase to increased benefits and administrative costs necessitated by repeal of the act. The rest of the increase was attributed to inflation, increased use of medical services, prior years' claim experience, and other factors. The Blue Cross and Blue Shield Association also surveyed its member organizations and found that the median increase in 1990 nongroup Medigap insurance premiums would be about 29 percent.

Medigap Insurance: Expected 1990 Premiums After Repeal of the Medicare Catastrophic Coverage Act and 1988 Loss Ratio Data, by Janet L. Shikles, Director of Health Financing and Policy Issues, before the Subcommittee on Medicare and Long-Term Care, Senate Committee on Finance (GAO/T-HRD-90-11, Feb. 2, 1990)

Following the Congress's repeal of the Medicare Catastrophic Coverage Act in November 1988, GAO surveyed 29 commercial insurers about their 1990 Medigap premiums. The 20 insurers that responded said they expect to increase their 1990 premiums by an average of 19.5 percent. Blue Cross and Blue Shield also surveyed its member organizations and found that the median increase among the 38 respondents for nongroup Medigap insurance premiums would be about 29 percent in 1990. After repeal of the act, the National Association of Insurance Commissioners revised its model regulation and minimum benefit standards for Medigap policies. These measures now protect consumers from some

abusive sale and marketing practices and require policies to cover more policyholder expenses, like Part B coinsurance after the beneficiary has paid the annual deductible of $75. GAO also testified on whether loss ratios met or exceeded minimum standards for insurers.

Medigap Insurance: Premiums and Regulatory Changes After Repeal of the Medicare Catastrophic Coverage Act and 1988 Loss Ratio Data, by Janet L. Shikles, Director of Health Financing and Policy Issues, before the Subcommittee on Health, House Committee on Ways and Means (GAO/T-HRD-90-16, Mar. 13, 1990)

GAO testified on its recent survey of 29 commercial Medigap insurers about their 1990 premiums for Medigap insurance. The 20 insurers that responded said they expected to raise their 1990 premiums for Medigap insurance by an average of 19.5 percent. The companies attributed about half of this increase to higher benefits and administrative costs necessitated by repeal of the Medicare Catastrophic Coverage Act. GAO also discussed the percentage of premiums paid out as benefits (the loss ratios) in 1988 and recent changes in federal and state regulatory requirements for Medigap policies. GAO identified several options for amending federal Medigap standards that could improve consumer protection and the economic value of Medigap policies.

Medigap Insurance: Proposals for Regulatory Changes and 1988 Loss Ratio Data, by Janet L. Shikles, Director of Health Financing and Policy Issues, before the Subcommittee on Commerce, Consumer Protection, and Competitiveness and before the Subcommittee on Health and the Environment, House Committee on Energy and Commerce (GAO/T-HRD-90-35, June 7, 1990)

GAO testified on H.R. 4840, the Medigap Fraud and Abuse Protection Act of 1990. This bill would expand consumer protections for the elderly who purchase Medigap insurance and would expand policy premiums and benefits during times that a policyholder is also eligible for Medicaid. GAO believes that enactment of this proposed legislation would go a long way toward improving consumer protections for purchasers of Medigap insurance. In GAO's view, the bill would also improve the economic value of this insurance. GAO also discussed 1988 loss ratio data.

National Institute of Health: Problems in Implementing Policy on Women in Study Populations, by Mark V. Nadel, Associate Director of National and Public Health Issues, before the House Select Committee on Aging (GAO/T-HRD-90-50, July 24, 1990)

The National Institutes of Health (NIH) has made little progress in implementing its policy to encourage the inclusion of women in research study populations. Although the policy first was announced in October 1986, guidance for implementation was not published until July 1989, and the policy was not applied consistently before the 1990 grant review cycles. Because implementation of the policy began so late, GAO could not determine its effects on the demographic composition of study populations. Furthermore, there is no readily accessible source of data on the demographics of NIH study populations, either from the NIH Director's office or from the institutes.

Potential Expansion of the CHAMPUS Reform Initiative, by David P. Baine, Director of Federal Health Care Delivery Issues, before the Subcommittee on Military Personnel and Compensation, House Committee on Armed Services (GAO/T-HRD-90-17, Mar. 15, 1990)

GAO examined two issues related to DOD's CHAMPUS Reform Initiative demonstration project: (1) the progress made in overcoming obstacles in implementing the initiative in California and Hawaii and (2) the adequacy of support for expanding the initiative into Arizona, Nevada, and New Mexico. GAO testified that DOD and its principal contractor—Foundation Health Corporation—have substantially improved claims processing, resource-sharing efforts, and financial management over the past year. However, GAO believes that any decision to expand the initiative should be delayed until there is more convincing evidence that the initiative is saving money—a key DOD element for judging its success. A delay would also allow DOD to determine whether the Foundation Health Corporation's progress under the contract is being sustained.

Quality of Care Provided Medicaid Recipients by Chicago-area HMOs, by Janet L. Shikles, Director of Health Financing and Policy Issues, before the Subcommittee on Health and the Environment, House Committee on Energy and Commerce (GAO/T-HRD-90-54, Sept. 14, 1990)

In a series of articles running in October 1987, the Chicago Sun-Times alleged that Chicago-area HMOs provided poor quality care to Medicaid recipients. Medicaid pays the Chicago-area HMOs a fixed monthly amount for each enrolled recipient to cover his or her health services. Although this practice has significant potential for containing health care costs, it also poses the danger of diminished quality of care. On the basis of its earlier report (GAO/HRD-90-81, Aug. 27), GAO testified that effective quality assurance mechanisms are not in place in the Chicago-area program to counterbalance the strong financial incentives given to

HMO physicians to underserve Medicaid patients. Further, the effects of such incentives on patient care cannot be adequately assessed until the HMOs fully and accurately document the medical care services provided and an effective system is developed to analyze the utilization data gathered.

Housing

Homelessness: Status of the Surplus Property Program, the Interagency Council on the Homeless, and FEMA's EFS Program, by John M. Ols, Jr., Director of Housing and Community Development Issues, before the Senate Committee on Government Affairs (GAO/T-RCED-90-98, July 19, 1990)

GAO testified on its work related to provisions of the McKinney Homeless Assistance Act. The Surplus Property Program, which is designed to identify surplus federal property available for homeless shelters, needs improvement. GAO believes that the government needs to be sure properties are truly surplus and available to homeless assistance providers before publicizing them as such, and that comprehensive federal guidance on how to obtain federal properties should be developed. GAO found that changes made by the Interagency Council on the Homeless have significantly improved the Council's services and operations; that review is detailed in an earlier report (GAO/RCED-90-172, July 11). Finally, GAO's review of the Emergency Food and Shelter Program administered by the Federal Emergency Management Agency revealed that funds are now reaching assistance providers in a more timely fashion than GAO reported previously.

Low-Income Housing Tax Credit Utilization and Syndication, by John M. Ols, Jr., Director of Housing and Community Development Issues, before the Subcommittee on HUD/Moderate Rehabilitation Investigations, Senate Committee on Banking, Housing, and Urban Affairs (GAO/T-RCED-90-73, Apr. 27, 1990)

Use of the low-income housing tax credit program has steadily grown since the program began, and today the program has become the nation's primary effort to encourage low-income housing production. GAO's testimony discussed three issues: (1) the amount of low-income housing tax credits allocated to states and awarded to projects for 1987 through 1989 and the number of low-income housing units developed in connection with these awards, (2) the syndication process used to help raise capital to finance low-income housing projects that have been awarded tax credits, and (3) the net amount of equity capital raised

through the syndication of projects awarded tax credits relative to the amount of the credit award.

If the tax credit program is to be continued on either a temporary or a permanent basis, GAO believes that adequate controls need to be developed to ensure that projects that receive credits are maintained and operated in accordance with program requirements. Projects that have been awarded credits should be carefully monitored to ensure that they continue to qualify for the annual credits by serving low-income families. These efforts should help discourage program abuses.

Potential Losses From the Rental Housing Inventory: Soundness of Current Estimates, by Eleanor Chelimsky, Assistant Comptroller General for Program Evaluation and Methodology, before the Subcommittee on Housing and Community Development, House Committee on Banking, Finance and Urban Affairs (GAO/T-PEMD-90-8, Feb. 28, 1990)

In recent years, several studies have suggested that, as private owners end their participation in federal housing programs by prepaying their mortgages, many federally subsidized rental units could be lost from the low- and moderate-income housing inventory. GAO testified on the preliminary results of its efforts to measure potential losses of federally subsidized units. GAO's findings suggest that the prepayment problem is closely tied to the opportunities available to property owners in a particular local market. For example, in the tight housing markets of Boston and Los Angeles, almost all the owners GAO spoke with would like to prepay as soon as possible; however, in low-demand markets like Denver and Houston, owners were far less likely to be interested in prepaying.

Use of Housing Subsidies, by John M. Ols, Jr., Director of Housing and Community Development Issues, before the Subcommittee on HUD/Moderate Rehabilitation Investigations, Senate Committee on Banking, Housing, and Urban Affairs (GAO/T-RCED-90-34, Feb. 27, 1990)

Its review of Sierra Pointe, a moderate rehabilitation project in Clark County, Nevada, leads GAO to conclude that there is a real danger of providing too much financial assistance to a developer when multiple subsidies are awarded to individual projects without a review of the total amount of assistance. For Sierra Pointe, a 160-unit project, GAO estimates that the developer realized cash flows of about $1.8 million, or about 22 percent, above the cost to acquire and rehabilitate the project. GAO also believes there is a real danger of using subsidies inefficiently. It

is inefficient to use the Moderate Rehabilitation Program and tax credits in housing markets that already have an adequate supply of rental housing. When Sierra Pointe was approved and during its development, GAO estimates that at least 160 suitable rental units would have been available to house low-income families. GAO has also reviewed seven other projects and is finding that it would have been more economical to have relied on existing housing using Section 8 certificates rather than on producing more units through a combination of moderate rehabilitation and tax credit subsidies.

Utility Allowances Provided to Public Housing and Section 8 Households and Resulting Rent Burdens, by John M. Ols, Jr., Director of Housing and Community Development Issues, before the Subcommittee on Housing and Community Development, House Committee on Banking, Finance and Urban Affairs (GAO/T-RCED-90-41, Mar. 7, 1990)

GAO testified on housing allowances provided to public housing and section 8 housing. Specifically, GAO discussed (1) the extent of utility allowances provided to those households, (2) the resulting rent burdens of households that receive these allowances, and (3) options available for changes.

Income Security

Audits of Employee Benefit Plans Need to Be Strengthened, by David L. Clark, Associate Director for Financial Management Systems and Audit Oversight, before the Subcommittee on Labor, Senate Committee on Labor and Human Resources (GAO/T-AFMD-90-25, July 24, 1990)

GAO testified on the role that independent public accountants play in auditing employee benefit plans covered by the Employee Retirement Income Security Act of 1974 (ERISA). Effective controls are necessary to safeguard the nation's employee benefit plans against mismanagement, fraud, and abuse. Independent public accountants are in a prime position to ensure that such safeguards are working to protect the interests of plan participants and the government. To that end, GAO believes that current audit provisions should be strengthened to more effectively use independent public accountants as an oversight and enforcement mechanism under ERISA.

Federal Government's Oversight of Pension and Welfare Funds, by Joseph F. Delfico, Director of Income Security Issues, before the Subcommittee on Oversight, House Committee on Ways and Means (GAO/T-HRD-90-37, June 13, 1990)

The Internal Revenue Service and the Department of Labor are responsible for ensuring that pension plans, with about $2 trillion in assets, and welfare benefit plans comply with ERISA. Their efforts have a significant impact on ensuring that employee benefit plans are free of mismanagement, fraud, and abuse. Of particular concern to GAO are the effectiveness of federal oversight of employee benefit plans that are essential to the well-being of millions of Americans, and the government's potential exposure to underfunding in pension plans insured by the Pension Benefit Guaranty Corporation. This underfunding is now estimated at between $20 billion and $30 billion in specific large plans. GAO testified on (1) the effectiveness of IRS's and Labor's ERISA enforcement programs and (2) Labor's proposals to enhance ERISA enforcement by strengthening independent public accountant audits.

Social Security: Comments on S.2453—The Social Security Restoration Act of 1990, by Joseph F. Delfico, Director of Income Security Issues, before the Subcommittee on Social Security and Family Policy, Senate Committee on Finance (GAO/T-HRD-90-29, May 11, 1990)

GAO has testified on most of the bill's provisions in the past. This testimony focused on provisions dealing with the hearings and appeals process, establishing a minimum staffing level at SSA, and changes to telephone access at SSA. GAO believes that the current appeals process takes too long. While S.2453 would shorten the process, GAO is concerned about the costs and services involved. Before proceeding, GAO believes that the process should be tested in several locations to determine potential costs. GAO supports reassessing staff levels to determine if reallocations due to staff imbalances can solve staff needs. Finally, GAO is concerned that the bill's proposal to list local SSA office phone numbers in the telephone book might undermine the new 800 system.

Social Security: Employment and Health Status of Social Security Denied Applicants, by Joseph F. Delfico, Director of Income Security Issues, before the Senate Special Committee on Aging (GAO/T-HRD-90-48, July 17, 1990)

The Social Security Disability Insurance Program is the main source of replacement income for workers who cannot work because of disabling health conditions. GAO summarized in testimony its 1987 survey of disability applicants who were denied benefits in 1984: over two-thirds of these nonworking denied applicants said they had been out of work for at least 3 years, and 54 percent did not expect to work again. The self-

described health status of denied applicants resembled that of beneficiaries, with most members of both groups reporting poor or fair-to-poor health.

GAO testified that these findings raise questions about the criteria used to determine an applicant's ability to work and about the determinations themselves. GAO noted that an applicant's residual functional capacity was the principal point of disagreement between state disability adjudicators who made initial decisions and administrative law judges to whom initial decisions are appealed. GAO believes that budget constraints during the past few years may be contributing to a decline in the quality of disability decisions, particularly denial decisions; from 1986 to 1989, the number of cases processed increased 12 percent while staff-years decreased 13 percent.

Social Security: Many Administrative Law Judges Oppose Productivity Initiatives, by Gregory J. McDonald, Associate Director for Income Security Issues, before the Subcommittee on Social Security, House Committee on Ways and Means (GAO/T-HRD-90-39, June 13, 1990)

SSA employs more than 700 administrative law judges (ALJs) in 132 hearing offices around the country to hear appeals of applications for social security or Medicare benefits that have been denied. These ALJs are unique federal employees in that they make decisions on administrative proceedings of the agency that employs them. Historically, SSA has used a monthly disposition goal to encourage the ALJs to decide more cases. Many of the ALJs, however, complain that SSA's emphasis on productivity has had a negative effect on their work. GAO's testimony focused on the issues of (1) performance goals and (2) staffing levels of both ALJs and support staff.

Social Security: Service to the Public—Accuracy of the 800 Phone Service, by Joseph F. Delfico, Director of Income Security Issues, before the Senate Special Committee on Aging (GAO/T-HRD-90-30, May 18, 1990)

Each year more than 60 million people call SSA's 800 number for a variety of reasons. GAO testified on SSA's methodology for evaluating the accuracy of information being provided to the public over the 800 line. GAO also discussed SSA's progress in stopping the withholding of Medicare catastrophic coverage premiums.

Social Security: Taxing Nonqualified Deferred Compensation, by Lawrence H. Thompson, Assistant Comptroller General for Human

Resources Programs, before the House Committee on Ways and Means (GAO/T-HRD-90-21, Apr. 5, 1990)

GAO testified on whether self-employed taxpayers use deferred income arrangements that achieve similar income tax treatments as plans called "nonqualified deferred compensation plans" used by employers and employees. These nonqualified plans are basically employer IOUs to pay employees future benefits in return for current services. GAO also provided information on how the imposition of the social security tax on employees using these kinds of plans differs from its imposition on self-employed taxpayers for similar types of income.

The Question of Rolling Back the Payroll Tax: Unmasking the Deficit Illusion, by Charles A. Bowsher, Comptroller General of the United States, before the Senate Committee on Finance (GAO/T-HRD-90-10, Feb. 5, 1990)

In the view of the Comptroller General, the use of growing Social Security surpluses to mask the federal deficit amounts to "blue smoke and mirrors." This practice has encouraged avoidance of the hard choices that must be made if the government is to bring its fiscal operations closer to balance. The current Social Security financing plan requires workers to pay a higher payroll tax than would be necessary under a pay-as-you-go system. While workers are left with the impression that this tax is being used to build reserves that will help pay for their future benefits, in fact the reserve is an illusion—a way to finance other general fund expenditures that we seem unwilling to ask taxpayers to pay for explicitly.

The illusion must end, and facts must be faced. GAO urges the Congress to take the steps necessary to ensure that the reserve accumulation has real economic meaning. The nation's political leadership must find a way to negotiate a multiyear, politically sustainable budget strategy. GAO hopes Senator Moynihan's tax rollback proposal will be the catalyst for such action.

The Social Security Administration's Supplemental Security Income Outreach Activities, by Joseph F. Delfico, Director of Income Security Issues, joint hearing before the Subcommittee on Retirement Income and Employment, House Select Committee on Aging (GAO/T-HRD-90-22, Apr. 5, 1990)

The Supplemental Security Income program provides financial support to the aged, blind, and disabled who have limited income and resources. Since the program began in the mid-1970s, there has been concern that many people who are eligible for the program are not participating. SSA, which administers the program, uses various outreach methods like radio, television, and speeches to increase awareness of the program.

However, GAO testified that more needs to be done to determine which outreach mode is the most effective. GAO surveyed SSA district office managers, a number of whom believe that not enough outreach is being done because of a lack of staff. GAO's survey also found that outreach for the non-English speaking needs particular attention. In addition, GAO testified on its evaluation of various Supplemental Security Income outreach demonstration projects sponsored by the American Association of Retired Persons.

Social Services

Older Americans Act: Dissemination of Research and Demonstration Findings Could Be Improved, by Joseph F. Delfico, Director of Income Security Issues, before the Subcommittee on Human Resources, House Select Committee on Aging (GAO/T-HRD-90-53, Sept. 11, 1990)

To spur ideas on how to improve services for the elderly, Title IV of the Older Americans Act provides discretionary funds to the Administration on Aging (AOA) to sponsor research and demonstrations projects. To be effective, however, project results need to be disseminated to agencies serving the elderly. GAO surveyed state agencies on aging in all 50 states and the District of Columbia and found that almost all are aware of some research and demonstration results. Moreover, most states' agencies use this information in shaping their programs and operations. However, GAO found that AOA disseminates results in an ad hoc and haphazard way and does not monitor how these results are used. State officials believe that the AOA could improve dissemination by publishing a summary of the results of completed Title IV projects and by conducting more conferences and seminars.

Veterans

VA Health Care Cost Recoveries, by Edward A. Densmore, Director of Planning and Reporting in the Human Resources Division, before the Subcommittee on Hospitals and Health Care, House Committee on Veterans' Affairs (GAO/T-HRD-90-40, June 20, 1990)

In April and May of 1990, GAO reported on efforts by VA to (1) collect from insurers the cost of health care provided to veterans without service-connected disabilities and (2) collect fees, generally referred to as copayments, from veterans who have income or assets above prescribed limits. While VA's collections exceeded its recovery costs, VA had the potential to collect substantially more than it did—perhaps another $223 million. Ineffective procedures and a reluctance to spend the resources needed to maximize recoveries contributed to missed collection opportunities.

In this testimony, GAO notes that VA has already responded to GAO's recommendations by (1) developing a comprehensive plan to improve its recovery procedures and (2) proposing legislation to improve the financing of its recovery efforts. GAO believes that VA is on the right road to realizing more fully its health care cost recovery potential.

Veterans' Benefits: VA Needs Death Information From Social Security to Avoid Erroneous Payments, by Gregory J. McDonald, Associate Director for Income Security Issues, before the Senate Committee on Veterans' Affairs (GAO/T-HRD-90-28, May 18, 1990)

VA provides about $15 billion in disability compensation and pension benefits each year. When a beneficiary dies, payments should cease. However, GAO found that in April 1989 VA made payments to over 1,200 veterans who, according to SSA records, were dead. About 100 of these veterans had been dead for 10 years or more. SSA receives death information from many sources, including employers and funeral homes. It also buys death certificate information from the states. While federal agencies like VA are authorized to obtain and use this information to ensure that payment records are correct, VA currently does not do so on a routine basis.

GAO testified that SSA and VA should establish a system to routinely share this information. GAO also indicated its support for S.1110, proposed legislation that would authorize VA to require social security numbers for its compensation or protected pension programs.

Ongoing Work as of September 30, 1990, Relating to Issues Affecting the Elderly

At the end of fiscal year 1990, GAO had 108 ongoing jobs that were directed primarily at the elderly, or had older Americans as one of several target groups. Of these, 2 were on food assistance issues, 46 on health issues, 10 on housing issues, 40 on income security issues, and 10 on veterans' issues.

Food Assistance

The Effectiveness of Survey Methodology, Planning, and Implementation of USDA's Nationwide Food Consumption Survey

The Quality of Canned Meat Procured by USDA for Commodity Distribution Program

Health

Alternative Enforcement Actions Needed to Assist HCFA in Assuring That Hospitals Comply With Medicare Requirements

Analysis of the Effectiveness of Medicare Automated Data Processing (ADP) Systems

Characteristics of the Uninsured in Selected States

Drug Utilization Reviews Under State Medicaid Prescription Drug Programs

Effect of Medicare's Durable Medical Equipment Fee Schedule on Program Payments and Alternative Payment Approaches

Electronic Medical Records: Analysis of Costs, Benefits, Impediments, and Risks in the Federal Hospital Community

Evaluation of Medicare Payments to Physicians for Medically Directing Nurse Anesthetists

Evaluation of Special Medicare Payments for Anesthesia Modifier Units

HCFA and Joint Commission Efforts to Assure Hospitals Meet Medicare's Requirements

HCFA's Internal Controls Over Payments to Peer Review Organizations

HCFA's Use of Review Screens to Control Medicare Payments

Hospitals' and Trauma Centers' Billing Practices for Medicare Trauma Cases

Impact of Applying Home Health Cost Limits by Discipline

Management of the Medicare Part B Carrier/Processor Transition Process

Medical Practice Guidelines: The Experience of Medical Specialty Societies

Medicare Overpayments Identified Under the Medicare Secondary Payer Provisions

Medicare Payments for Durable Medical Equipment

Medicare Peer Review Organization Administrative Requirements Imposed on Hospitals

Medicare Provider Audits

Medigap Insurance and Employer Maintenance-of-Effort Actions Under Medicare Catastrophic Coverage

OBRA-86 Secondary Payer Provision: Evaluation of Savings and Effects on Disabled Medicare Beneficiaries

Off-Label Drugs: A Study of Reimbursement for Cancer Patients' Care

Outpatient Surgery: A Survey of Medicare Patient Outcomes

Private Sector Initiatives in Managed Care: Lessons for the Medicare Program

Recovery of Medicare Part B Overpayments

Review of Independent Clinical Laboratories' Profits Under the Medicare Fee Schedule

Review of Medicaid Drug Acquisition Costs and Overhead Costs of Retail Pharmacies

Review of Medicaid Third Party Liability Recoveries From Insurance Located Outside the Home State

Review of Medicare Payments to Anesthesiologists

Review of Medicare's Professional Review Organization Program for Health Maintenance Organizations

Review of Medicare's Use of Beneficiary Complaints to Detect Waste and Abuse

Review of Michigan's Medical Malpractice Arbitration Program

Review of Recoveries for Medicaid Services Covered by Private Insurers in Michigan

Review of the Appropriateness of Medicare Payments for Durable Medical Equipment

Survey of Alternative Resolution Procedures for Medical Malpractice Claims Involving Services Provided Through Medicare

Survey of Alternative Ways of Reimbursing Physicians' Malpractice Insurance Premiums Associated With Services Provided to the Elderly and Disabled and Paid for by Medicare Part B

Survey of Factors Influencing Medicare Hospital Costs and Payments

Survey of Long-Term Care Insurance Policyholder Protection

Survey of Medicaid Third-Party Liability

Survey of Medicare's HMO Rate-Setting Methodology

Survey of Methods Used to Fund Community Health Centers

Survey of Need to Establish a Heat Wave Warning System

Survey to Determine the Magnitude of Medicare Credit Balances and the Impact on the Medicare Program

The Efficacy-Effectiveness Interface: A Methodology for Determining "What Works" in Medicine

Variation in HCFA Regions' Interpretations of Medicaid Coverage of Substance Abuse

Ways in Which the Federal Government Can Complement Staff Efforts to Improve Access to Health Care Centers

Housing

Access to McKinney Act Programs Improved But Better Oversight Needed

Chronically Mentally Ill in Public Housing and Their Impact on Elderly Tenants

Evaluation of Processing Delays in the Section 202 Elderly Housing Program

How Effective is the Federal Surplus Personal Property Donation Program?

HUD's Plans and Progress to Address Problems Surfaced in the Past Year

Review of Mentally Disabled Tenants in Public Housing and Their Impact on Elderly Tenants

Review of the Effectiveness of HUD's Supportive Housing Demonstration Program

Review of the Elderly's Use of Housing Vouchers as Compared With Other Forms of Assisted Housing

Status of the Surplus Property Program, The Interagency Council on the Homeless, and FEMA's EFS Program

Use of Surplus and Underutilized Federal Property for the Homeless

Income Security

Adequacy of SSA Procedures for the Use of Medical Advisors in Hearings and Appeals Decisions

Analysis of a Proposal to Privatize Social Security Trust Fund Reserves

Benefit Distribution in Small and Large Employers' Pension Plans

Briefing Report on Program Characteristics of the Low-Income Home Energy Assistance Block Grant

Differences Between Men's and Women's Pensions at Retirement After Adjusting for Difference in Salary and Tenure

Effects of Fractional Accrual Rule on Equity of Private Pension Plan Benefits

Ensuring Income Security for the Elderly: Federal/State Roles and Coordination of Community Support Services

Equal Employment Opportunity Commission: Management of Age Discrimination Charges to Prevent Lapses

Evaluation of SSA Debt Management Practices

Follow-Up Study to Analyze How and Why SSA Denied Disability Benefits to Many Severely Impaired Applicants

Georgia's Compliance With Administrative Cost Provisions of LIHEAP Legislation

How Effective Is SSA's Effort to Assist SSI Applicants Apply for Food Stamps?

How Should the Amount of Tax Revenues Owed to the Social Security Trust Funds Be Determined?

Impact of Companies Filing for Bankruptcy on Retiree Health Benefits

IRS Enforcement of the Employee Retirement Income Security Act of 1974

Junk Bond Holdings by Pension Funds

Leveraged Buy-Outs Effect on Pension Benefit Security

Management of VA: Human Resource Management Vital to Success of the Secretary's Strategic Management Process

Office of Hearings and Appeals' Processing of Medicare Appeals

Older Americans Act: State Voluntary and Mandatory Elder Abuse Reporting Systems

Review of Employee Stock Ownership Plans

Review of Financial Assumptions Used in Estimating Defined-Benefit Pension Plans' Liabilities

Review of Low-Income Home Energy Assistance Program Block Grant

Review of Pension Fund Investments in Low- and Moderate-Income Housing Projects

Review of the Nature and Extent of Supplemental Security Income Outreach of SSA Field Offices

Review of the Railroad Retirement Board Activities

Secretarial-Level Oversight of VA Programs and Administrative Activities

Social Security's Actions to Recover Checks Sent to a Deceased Beneficiary

SSA Capping Report on ADP and Telecommunications

Study of Tenant Income Reporting and Verification in HUD Assisted Housing

Survey of Feasibility of Enhancing SSA's Enumeration Verification System to Detect Dual Welfare Benefit Claims

Survey of Fiduciary Breaches in Pension Plans Terminated for Bankruptcy by Plan Sponsors

Survey of SSA Death Notice Procedures

Survey of SSA's Acquisition and Processing of Death Information

Survey of the Accuracy of the Answers Provided Via SSA's 800 Telephone Service

Survey of the Effectiveness of the Federal Government's Effort to Automate State Welfare Programs

Survey of Unreimbursed Expenses Reported by VA Pension Beneficiaries

Survey of VA Insurance Program Management

Testimony on Equity of Medicaid Formula Distribution

Trends in Joint and Survivor Selection Rates Before and After Passage of the 1984 Retirement Equity Act

Veterans

Assessment of VA's Health Care Services for Women Veterans

Assessment of VA's Prescription Drug Refill Policies, Procedures, and Practices

Evaluation of VA's Administration of the Medical Care Means Test

Evaluation of VA Expenditures for Private Health Care

Monitoring of VA Mortality Study Follow-up

Review of the Diagnosis and Treatment for Alcoholism at VA Medical Centers

VA's Drug Security Policies, Procedures, and Practices

VA Efforts to Assure that Psychiatric Patients Receive Quality Care

VA Quality Assurance and Joint Commission Standards: Noncompliance at VA and Non-VA Hospitals

VA's Use of Part-time Physicians in Its Health Care System

Activities by GAO Officials

During fiscal year 1990, GAO officials spoke, presented papers, conducted seminars, and participated on panels 42 times on issues relating to aging: once on food assistance issues, 26 times on health issues, 6 times on housing issues, 4 times on income security issues, and 5 times on social services issues.

Food Assistance

Jerry Killian and Ken McDowell, Resources, Community, and Economic Development Division, discussed GAO's reviews of food assistance program requirements, before the National Frozen Food Association's Government Relations Committee, Washington, February 14, 1990.

Health

Eric Anderson, Human Resources Division,

- discussed GAO's role in the policymaking process and its work on aging and health issues, before the University of Southern California's graduate policy seminar for students in gerontology and public policy, Washington, October 5, 1989.
- spoke on "Nursing Homes: Equity of Access for Medicaid Recipients," before the Gerontological Society of America's scientific meeting, Minneapolis, November 18, 1989.

Jerry Baugher and Pete Oswald, Human Resources Division, discussed GAO's review of cataract surgery, before the Health Care Financing Administration's Cataract Demonstration Work Group, Baltimore, May 24 and June 7, 1990.

James Cantwell, Human Resources Division, chaired a session and presented a paper, "Changing Medicare Part B Deductible," at the Western Economic Association meetings, San Diego, California, June 30, 1990.

Mary Ann Curran, Human Resources Division, discussed GAO's reviews of actions by HCFA and the Joint Commission on the Accreditation of Healthcare Organizations to assure quality care in hospitals, at the annual meeting of the Association of Health Facility Licensing and Certification Directors, Orlando, Florida, October 13, 1989.

Robert Dee, Boston Regional Office, discussed GAO's report, Medicare: Impact of State Mandatory Assignment Programs on Beneficiaries (GAO/HRD-89-128, Sept. 19, 1989), at the annual meeting of the American Public Health Association, Chicago, October 22-26, 1989.

Nancy Donovan, New York Regional Office, presented a paper cowritten with Ed Stropko, Human Resources Division, on eligibility criteria and cost-sharing for long-term care, at the annual meeting of the Gerontological Society of America, Minneapolis, November 18, 1989.

Nancy Donovan, Janet Shikles, and Edwin Stropko, Human Resources Division,

- submitted a paper, "Use of ADLs as Eligibility Criteria for Long-Term Care," at the Third International Conference on Systems Science on Health-Social Services for the Elderly and Disabled, Bologna, Italy, April 20, 1990
- ran a booth advertising GAO's health care work at the annual meeting of the American Society on Aging, San Francisco, April 5-8, 1990.

Michael Gutowski, Human Resources Division, discussed "Cost-Sharing for In-Home Services: Towards a More Equitable Distribution of Service Costs," at the annual meeting of the American Public Health Association, Chicago, October 22-26, 1989.

Roger Hultgren, Human Resources Division, discussed GAO's report on physician incentive payments by HMOs, at a symposium on health care cost containment sponsored by Seton Hall University Law School, Elizabeth, New Jersey, October 13, 1989.

Marsha Lillie-Blanton, Human Resources Division, spoke on "Health Care for the Nation's Poor: System or Non-System," before the American College of Preventive Medicine, Atlanta, April 21, 1990.

Jim Linz, Human Resources Division, spoke on changes in Medicaid mental health benefits, before the National Association of Counties' legislative conference, Washington, March 19, 1990.

Wayne Marsh, Sacramento, and Ben Ross, Human Resources Division, discussed GAO's reviews of state comprehensive mental health plans, before the winter 1989 meeting of State Mental Health Directors, Rosslyn, Virginia, December 11-12, 1989.

Tom Monahan and Jim Hampton, San Francisco, discussed the "GAO Culture" and presented a case study of GAO's review of the Medicare schedule for clinical laboratory service reimbursement, before the Presidential Management Internship Program Western Career Development Group, San Francisco, July 10, 1990.

Frank Pasquier, Seattle Regional Office, discussed GAO's reviews of Medicare's secondary payer program, before the National Medicare Secondary Payer Conference, Hilton Head, South Carolina, November 28, 1989.

Kalman Rupp, Human Resources Division, presented a paper, "Medicare HMO Ratesetting: The Issue of Systematic Risk," at the annual meeting of the American Economics Association, Atlanta, December 28-30, 1989.

Sushil Sharma, Program Evaluation and Methodology Division,

- chaired a symposium, "Federal Government, Elderly, and Medication—Signals for Prescribers, Dispensers, and Patients," at the annual meeting of the American Public Health Association, Chicago, October 22-25, 1989.
- presented a paper, "Evaluation of Drug Utilization Programs—A Methodological Challenge," at the School of Pharmacy, University of Washington at Seattle, July, 1990.

Sushil Sharma and James Solomon, Program Evaluation and Methodology Division,

- co-authored an article, "Third Party Reimbursements for Counseling Needed," published in Hospital Economics, vol. 2, September 1990.
- presented a paper, "Reimbursement of Cognitive Services in Third Party Programs," at the annual meeting of the American Pharmaceutical Association, Washington, D. C., 1990.

Janet Shikles, Human Resources Division, discussed "Major Health Issues and the 101st Congress," before Yale's Graduate School of Public Health, New Haven, Connecticut, February 8, 1990.

Sheila Smythe, Human Resources Division,

- discussed "Tough Choices—Controlling Health Care Costs," at a conference sponsored by the Investment Management Institute, New York, January 23, 1990.
- was a presenter in a session, "Health Care Policy: The Private Sector's Role," at the American Society for Public Administration's national conference, "Public Service Partnerships: Innovations for the 21st Century," Los Angeles, April 7-11, 1990.

James Solomon, Program Evaluation and Methodology Division, presented a paper, "Possible Repeal or Scaling Back of the Medicare Catastrophic Coverage Act of 1988: Lessons Learned," at the annual

meeting of the American Public Health Association, Chicago, October 22-25, 1989.

Michael Stepek, Philadelphia Regional Office, and Roger Hultgren, Human Resources Division, discussed GAO's analysis of loss-ratio data for Medicare supplemental insurance, at a Medigap roundtable discussion cosponsored by the American Bar Association and Families USA, Washington, March 22, 1990.

Housing

Bob Barbieri, New York Regional Office, spoke on GAO's role in the future of homelessness, in a plenary session, "Homelessness in the 1990's," at the fourth annual conference of the Colorado Coalition for the Homeless, Denver, October 25-26, 1989.

John Ols, Resources, Community, and Economic Development Division, discussed GAO's reviews of housing and homelessness, and moderated a panel discussion on housing issues, at the annual meeting of the Urban Affairs Association, Charlotte, North Carolina, April 19-20, 1990.

Tom Repasch, New York Regional Office, and Gene Aloise and Marnie Shaul, Resources, Community, and Economic Development Division, discussed GAO's report, Homelessness: Too Early to Tell What Kinds of Prevention Assistance Works Best (GAO/RCED-90-89, Apr. 24, 1990), before the Interagency Council on Homelessness, Washington, May 29, 1990.

Tom Repasch, New York Regional Office, participated in a panel discussion, "Prevention of Homelessness: Examination of Effective Models," at the fourth annual conference of the Colorado Coalition for the Homeless, Denver, October 25-26, 1989.

Tom Repasch and Bryon Gordon, New York Regional Office, discussed the region's work on homelessness, before policy analysis classes at Syracuse University, November 1, 1989.

Tom Repasch and Wendy Bakal, New York Regional Office, participated in a panel discussion, "Prevention: Developing a Homeless Prevention Fund in Colorado," at the fourth annual conference of the Colorado Coalition for the Homeless, Denver, October 25-26, 1989.

Income Security

Ken Bombara, Human Resources Division, discussed "The Accumulation of Social Security Trust Fund Reserves: Implications for Policy," at the

annual meeting of the American Society on Aging, San Francisco, April 5-8, 1990.

Glenn Davis, Human Resources Division, discussed the use of age discrimination waivers in company exit incentive programs, at the annual meeting of the American Society on Aging, San Francisco, April 5-8, 1990.

Donald Snyder, Human Resources Division, discussed Medicare catastrophic insurance and retiree health plans, at the annual meeting of the American Society on Aging, San Francisco, April 5-8, 1990.

Sharon Ward, Human Resources Division, discussed pension rules and benefit inequities in small pension plans, at the annual meeting of the American Society on Aging, San Francisco, April 5-8, 1990.

Social Services

David Bixler, Human Resources Division, discussed "GAO and Its Approach for Studying the Family Support Act of 1988," before the American Public Welfare Association's National Council of State Human Services Administrators, Washington, February 28, 1990.

Michael Gutowski, Human Resources Division, discussed GAO's report, In-Home Services for the Elderly: Cost Sharing Expands Range of Services Provided and Population Served (GAO/HRD-90-19, Oct. 23, 1989), at the Roundtable on Cost Sharing, sponsored by the Administration on Aging, Washington, December 14, 1989.

Marsha Lillie-Blanton, Human Resources Division, discussed "The At-Risk Population in the District of Columbia," at a symposium sponsored by the D.C. State Planning and Development Agency, Washington, April 30, 1990.

James Solomon and Sushil Sharma, Program Evaluation and Methodology Division, coordinated a seminar on information and assistance programs and information flow within aging networks for the Senate Select Committee on Aging, Washington, April 19, 1990.

James Solomon, Program Evaluation and Methodology Division, moderated a seminar, "Older Americans Act—Critical Issues," for the Senate Select Committee on Aging, Washington, January 30, 1990.

GAO Activities Regarding Older Workers

GAO appointed 706 persons to permanent and temporary positions during fiscal year 1990, of whom 137 (19 percent) were age 40 and older. Of GAO's total work force of 5,235 on September 30, 1990, 2,869 (54.8 percent) were age 40 and older.

GAO employment policies prohibit discrimination based on age. GAO's Civil Rights Office continues to (1) provide information and advice and (2) process complaints involving allegation of age discrimination.

GAO continues to provide individual retirement counseling and preretirement seminars for employees nearing retirement. The counseling and seminars are intended to assist employees in

- calculating retirement income available through the Civil Service and Social Security systems and understanding options involving age, grade, and years of service;
- understanding health insurance and survivor benefit plans;
- acquiring information helpful in planning a realistic budget based on income, tax obligations, and benefits, and making decisions concerning legal matters;
- gaining insights and perspectives concerning adjustments to retirement;
- increasing awareness of community resources that deal with preretirement planning, second career opportunities, and financial planning; and
- increasing awareness of lifestyle options available during the transition from work to retirement.

Major Contributors to This Report

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